

**HIT Policy Committee – Strategic Plan Workgroup  
Listening Session  
Draft Transcript  
April 6, 2010**

**Presentation**

**Judy Sparrow – Office of the National Coordinator – Executive Director**

Good afternoon, everybody, and welcome to the strategic plan workgroup. This is a listening session. We're going to be talking about the Health IT Strategic Framework Paper, which has been broken up into four sections, so this is a little different. There'll be opportunity after each section for the public to make comments. Just a reminder to keep your phone on mute when you're not speaking, and the framework paper, along with the agenda, and the PowerPoint's are on the ONC Web site, [healthit.hhs.gov](http://healthit.hhs.gov). Let me do a quick roll call. Paul Tang?

**Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO**

Here.

**Judy Sparrow – Office of the National Coordinator – Executive Director**

Jodi Daniel?

**Jodi Daniel – ONC – Director Office of Policy & Research**

Here.

**Judy Sparrow – Office of the National Coordinator – Executive Director**

Paul Eggerman?

**Paul Eggerman – eScription – CEO**

Here.

**Judy Sparrow – Office of the National Coordinator – Executive Director**

Deven McGraw?

**Deven McGraw - Center for Democracy & Technology – Director**

Here.

**Judy Sparrow – Office of the National Coordinator – Executive Director**

Dave McCallie?

**David McCallie – Cerner Corporation – Vice President of Medical Informatics**

Here.

**Judy Sparrow – Office of the National Coordinator – Executive Director**

Charles Kennedy? Carol Diamond? Art Davidson?

**Art Davidson - Public Health Informatics at Denver Public Health – Director**

Here.

**Judy Sparrow – Office of the National Coordinator – Executive Director**

John Lumpkin? Steve Findlay?

**Steve Findlay – Consumers Union – Senior Healthcare Policy Analyst**

Here.

**Judy Sparrow – Office of the National Coordinator – Executive Director**

Jim Walker? Christine Bechtel?

**Christine Bechtel - National Partnership for Women & Families – VP**

Here.

**Judy Sparrow – Office of the National Coordinator – Executive Director**

Mark Frisse?

**Mark Frisse – Vanderbilt University – Accenture Professor Biomed Informatics**

Here.

**Judy Sparrow – Office of the National Coordinator – Executive Director**

Cris Ross? Steve Stack? Janet Corrigan? Penny Thompson? Don Detmer?

**Don Detmer – American Medical Informatics Assoc. – Pres. & CEO**

Here.

**Judy Sparrow – Office of the National Coordinator – Executive Director**

Patricia Brennan?

**Patti Brennan – UW-Madison – Moehlman Bascom Professor**

Here.

**Judy Sparrow – Office of the National Coordinator – Executive Director**

Tony Trenkle? Marc Probst?

**Marc Probst – Intermountain Healthcare – CIO**

Here.

**Judy Sparrow – Office of the National Coordinator – Executive Director**

And David Lansky?

**David Lansky – Pacific Business Group on Health – President & CEO**

Here.

**Judy Sparrow – Office of the National Coordinator – Executive Director**

Thank you. I'll turn it over to Jodi Daniel.

**Jodi Daniel – ONC – Director Office of Policy & Research**

Welcome, everyone, and thank you all for joining us today for this listening session on the Health IT Strategic Plan. We have folks joining us via the Web and via the phone to participate in this discussion. We had a really good response to the listening session. We had over 1,000 people who signed up to participate in this session, so we're looking forward to some great public input on the work that has been

done to date. For folks who are trying to get online, the first 500 people will be able to log into the Web, and the others will have to join us by phone. All of the material is available up on our Web site, everything that we will be presenting on the Web, so you should still be able to follow along based on the material that we have made available.

This session is being hosted by our strategic plan workgroup of the Health IT Policy Committee, which is a federal advisory committee that provides recommendations to the National Coordinator for Health Information Technology on various health IT policy topics. The HITECH Act required ONC to update our health IT strategic plan, and this workgroup is charged with making recommendations in the form of a strategic framework to the fully committee, and then ultimately to the National Coordinator. We're expecting that the recommendations from this workgroup, through the policy committee, will inform our update to the federal health IT strategic plan, which ONC will be working on this summer. The original plan was released in June of 2008, and we're hopeful that we will have an updated plan this fall, the fall of 2010.

The purpose of today's session is to hear your comments on the framework that the health IT policy committee strategic plan workgroup has developed to date, and we've made that document available on our Web site. We're expecting that your feedback will help us know, help the committee know if we're heading in the right direction, help identify if we need to make any changes, any areas of prioritization that we should be thinking about so that the workgroup can consider that input before making final recommendations to the policy committee and ultimately to the National Coordinator.

We've also started a FACA blog where you can submit comments on the framework as well, and I'll talk about that in a little bit. So we're looking for input, both on this session, as well as if something sparks a thought in your mind after the session, and you want to get comments back, there's still an opportunity to do that, or if you don't get through during the comment period on this phone call.

I wanted to, one, thank all of our committee members who have worked very hard through lots of meetings, discussions, and reviews of the strategic framework that we have to date to pull this off to what it is right now and will be processing all the input they get together. Then I wanted to walk through the agenda briefly so that folks know what to expect for the next few hours. So the session agenda will be as follows. First we'll have Dr. Paul Tang to serve as the chair of the strategic plan workgroup, as well as the vice chair for the overall Health IT Policy Committee, and he's going to provide an overview of the draft health IT strategic framework that the workgroup has developed.

Then we'll have four presentations that will cover the four major sections of the framework on each of the four themes. We'll have brief presentations because we really want to hold most of the time for your input and discussion, so we'll have ten-minute presentations for each of these four sections. And then there'll be opportunity for comments or questions on the framework for each section, and we'd like you to please keep your comments to the section that we're discussing at that time so that we can sort of focus the discussion as much as possible.

There are two ways to make comments or questions on the framework during the session. As I mentioned, there will be the FACA blog, which will remain open through April 11<sup>th</sup>, and the URL will be on the slides, so you'll have that as well. You can also send comments or questions online if you prefer, or you can ask a question verbally during the public comment segment after each presentation. We ask that those keep their comment or question to 1.5 minutes, so we can get as many people to have an opportunity to speak as possible during each session.

I'd like to just take a second to thank all of the members on the workgroup for their contributions. We have many of the workgroup members participating on the phone today, and there'll be an opportunity for them to respond as well for each section of the discussion. So we'll both take comments. We'll look at the online comments. We'll look at the blog responses, and we'll be considering the verbal discussion today through the workgroup, and we expect that it'll help refine, hone, and improve upon the health IT strategic framework that the workgroup has developed thus far.

I just want to take one minute to thank everybody for providing us with the time and with your comments and thoughts. We really value the input of all of the stakeholders, all of the different perspectives in getting this to be as good a document as possible and really help shape the work of ONC and HHS for years to come. With that, I will turn it over to Paul Tang to get us started on the agenda.

**Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO**

Thank you very much, Jodi. Before beginning the formal program, I just wanted to offer a few words of acknowledgement and to express our gratitude for really the tremendous dedication and hard work of the staff and the officials in the Office of the National Coordinator. The HITECH timeline that was laid out was really aggressive, and the staff is constantly working a break neck speed to meet all of those milestones, so I think we all in the country owes this group a tremendous debt of gratitude.

I also want to acknowledge, as Jodi did, the enormous amount of dedication and volunteer time that all the folks on this particular workgroup, but also the HIT Policy Committee and all of the testifiers to the committee. Everyone, I think, is coming in trying to make a difference and to advance the cause for health and healthcare in this country, and it's been greatly appreciated. I know Dr. Blumenthal appreciates all of the advice and recommendations he gets from this group, so I appreciate it. And the public, as Jodi said, has been crucial in forming the recommendations.

This is a program a lot of people think of the \$27 billion HIT incentive, but there's also a \$2 billion program that ONC manages, and there's a lot of components to that program that make it go under the radar ... but really have a lot to do with paving the infrastructure for what we're going to talk about, which is in our learning health system. And so speaking of the learning health system, that has become, at least for this group, our recommendation expectation for healthcare systems in the future, and health and healthcare systems in the future.

We borrowed from the Institute of Medicine's roundtable on evidence-based medicine. I know they changed the name, but it's hard to change your thinking once they've changed the name. But they have a roundtable that has a series of symposia and work sessions that talk about how we go about building a better evidence base for what we do in this country in the name of health. The vision they created for a learning health system is one that is designed to generate and to apply the best evidence for collaborative health choices of each patient and provider to drive the process and new discovery as a natural outgrowth of patient care and to insure the innovations, quality, safety, and value in healthcare. A very powerful and provocative vision, I think, so we've adopted that as the vision for the health system in the future of this country.

What does that mean? It means that we operate to serve the best interest of each individual patient, so we want to use the HIT infrastructure in a way that allows us to continuously learn and to apply these learnings to individual care. For example, a system should help; the HIT system should help the healthcare professional apply the best evidence and decisions for an individual patient. The system should help provide patients with information and knowledge to participate in their own collaborative decisions about their care in health. And it should support the learnings from all patient data with, of

course, appropriate patient consent and privacy protection in place to help us discover new knowledge, to advance the quality, safety, and value of healthcare.

To create this environment for a learning health system, a number of infrastructure planks need to be created and supported. We've put together maybe a little complex, but I'll walk you through this diagram that tries to illustrate what we mean by a learning health system. At the top, of course, is what we want to deliver to the patients, and that is the IOM ... delivering patient centered, safe, timely, effective, efficient, and equitable care.

To put that in place in the middle section, there are a number of activities that go on in this health system. We engage consumers. We provide care. We measure quality. We continuously improve and innovate in our processes. We educate, and we conduct research to always improve the knowledge base upon which we've ... deliver these services. And the beneficiaries are numerous, so listed on the right are consumers, patients, providers, payers, the public health at large, the professionals, and researchers. If everything is working right, we use this tremendous information about the experience of care manifested as data to produce the results. That is, patients are more informed. Care is improved. The quality of care has improved. We have improved outcomes for individuals, as well as the population. We enhance the value of the health system, and we create new, shared knowledge.

To get there, we've sort of constructed and what we'll be reviewing in this listening session are sort of four planks, and those appear at the bottom. First, we have to have a policy at the very bottom is a policy and a technical infrastructure that allows data to flow seamlessly among the multiple interoperable components, components in computers. Next, we consider a foundational plank or infrastructure layer, which is privacy and security infrastructure that allows data to flow securely, but only for authorized uses. Then on top of that then you have a series of systems that, together, for example, comprise electronic health records, personal health records, other HIT elements that, when meaningfully applied, achieve these improved health outcomes that we desire. Through this listening session, we're going to go through each of these layers and offer time for your comments.

Just a moment to spend on a depiction of the current ONC activities, as manifested in Dr. Blumenthal's *New England Journal* article a couple months ago. Again, sort of at the top, feeding right into this learning health system is the meaningful use of certified EHRs. A lot of people have heard about that one. But maybe less visible and less vocal is a word about, on the left side, the adoption of EHRs. It's not just asking for EHRs to be adopted. There are a number of proactive steps and programs that are in place, such as the regional extension centers, the supplement to help the workforce be trained to use these things. The additional grant funding to universities to produce programs that train not only the professions who build and develop and improve these systems, but also who teach the workforce to use them effectively.

On the right, it deals a lot with the connectivity. One of the most challenging problems we've had in this whole exercise, which is to seamlessly change health information amongst the various systems. And so there has been state grants for health information exchange organizations. There's a standards and certification framework in the various NPRMs and the privacy and security framework that underpins all of this.

Finally, there's a research component, and there were grants just released last week that support continuously improving the actual knowledge in creating the assistance, making them better, offering more evidence base to both the systems themselves, as well as the advice they give to clinicians who are in the frontline. So this is sort of the current framework or outline for the current activities, and we expect

these will be supported by the new framework we're developing as recommendations for the strategic plan going forward. So there'll probably be these activities, as well as others.

The first thing we're going to talk about of the four planks is the learning health system. A number of folks from the workgroup, the strategic plan workgroup are going to walk us through this, and that, as we mentioned earlier, we'll start out with sort of an overview, and then open up for public comments for 25 minutes for each of these components. We're going to start out with the learning health system, and Patti Brennan is going to walk us through that one.

**Patti Brennan – UW-Madison – Moehlman Bascom Professor**

Thank you very much, Paul. Thank you all who are joining us in this listening session. I'm going to be making references to the document that's available on the ONC Web site that's entitled Health IT Strategic Framework. As the first of the four speakers who will be addressing, there are key elements of the strategic framework or key themes. I'd like to just highlight two or three aspects of the background before we go into the specific consideration of the learning healthcare system.

The strategic planning process, as was noted earlier, has been going on since late last fall. We came together around a vision that is a learning healthcare system following the institute of medicine ideas of what a learning healthcare system is about. The anticipation is that this will occur through a number of different activities coordinated through ONC, and we recognize that a strategic plan is a living document, that it will be growing through interactions such as this, and growing in the future.

On page six of the strategic plan, there are some key issues and challenges that you may think about, as we're going through our descriptions today. Some of them deal with the balancing of short-term need versus long-term uncertainties. Others address issues such as personal choice and public engagement or a balancing, transparency, and access, as well as monitoring the unintended consequences of HIT. So we consider the number of factors, as we began to address these specific themes. And you'll see them emerging as we go through each of the individual themes.

We're going to start though at the final theme, which is the learning healthcare system, and discuss with you how we see this evolving under the new strategic plan. As you'll hear each of our four themes, we'll begin with the goal, and then we'll discuss principles that drove the thinking about that goal. We then move on to objectives related to that goal and, finally, strategies.

Let me begin then with the idea of the learning healthcare system. Our goal is to create, to transform the current healthcare delivery system into a high performance learning system by leveraging both health information, as well as health information technology. Please note that we separated these two ideas, emphasizing the importance of both the health information and the technologies needed to acquire that information, to make it available to clinical practice and research, and to store it in a secure fashion. A learning healthcare system, as Paul emphasized earlier, is responsive to the needs of the patient and mindful of knowledge of the population overall. The learning healthcare system is supported by information technologies that capture information at the point of care, integrate that information into the larger knowledge base, and return advice and directions back to the point of care, thus creating a full circle.

Now if we can move to the next slide, please, the principles that will drive the discussion of the learning healthcare system began with an idea first that health information should be used to facilitate rapid learning and innovation in the diagnosis, treatment, and decision making to improve health outcomes and to increase health value. Second, the health information technologies should help patients and providers

to take active roles in the creation and application of evidence-based care. Let me comment on each of these principles before we go on to the objectives.

First, the idea that health information is an important asset in a healthcare delivery system designed to insure that the system is nimble and responsive, so the information that we acquire should be used to facilitate bringing up to date the most current information to the point of care and to bring innovations and diagnosis, treatment, and decision making to the point of care with the goal of improving the outcomes of an individual, family, or community, as well as to enhance the value of the healthcare delivery system. The idea is that health information fits into the overall process of the delivery of healthcare and the insurance that healthcare is provided in a manner that is competent and efficient and up to date.

Now we recognize in principle two that health IT should be used not only for professionals, but also for patients to insure that both parties can take active roles in the creation and application of evidence-based care. This principle is particularly important to our team's work because we recognize that the healthcare delivery system and the health system overall are two separate concepts. People live every day with health challenges and health problems, and they experience health in everyday living. So as we think towards the function of a learning health system, we need to think both about the experience in the delivery sector side and the information tools needed to insure that healthcare delivery is efficient and safe, as well as in the experience of everyday living, the health side of this.

Principle number two emphasizes the importance of health IT in engaging individuals and providers in taking an active role in the creation and application of evidence-based care. Through health IT, we should learn new things about health and everyday living, and be able to integrate that into the process of delivering care to an individual. In addition, the care should be increasingly evidence-based. We should have a sound knowledge base for understanding why certain treatments are provided or not provided, why therapies are initiated or ceased.

Now that evidence has traditionally come from the research literature and should continue to do that. The health IT system will ideally support a vibrant translational research agenda. But in addition, other kinds of evidence such as the experience of individuals or the environmental situations they find themselves in must be incorporated in the scientific evidence that's provided.

Now I'm going to turn to the objectives. This slide is a little dense. I'm going to ask you to let me read it through, and then I'll make some comments in each area.

The first objective for a learning health system is to use health IT methodologies, policies, and standards to foster creation of knowledge across a large network of distributed data sources while protecting privacy and confidentiality. The second objective is to engage public and private sector stakeholders at the national, regional, and local levels to effectively leverage data and human resources to advance healthcare delivery, align payment with outcomes, conduct research of various types, including clinical research, comparative effectiveness research, and other new types of translational research, enhance public health through drug safety monitoring, for example, or outbreak surveillance. Educate professions in the public, including K-12, colleges, professional schools, and professional life-long learning. And, finally, leverage social services to promote and maintain community health.

I'll comment on each of these briefly. The first objective addresses the use of emerging health methodologies, as well as policies and standards with the goal of creating knowledge from distributed data resources. So we are emphasizing very heavily in this first objective, methodologies that enhance the health data exchange and build on the emergence of new kinds of architectures.

Our second objective says specifically, we need to engage public and private sector stakeholders. This includes individuals, institutions, vendors, industry, local and national government groups to effectively leverage health data and human resources for a number of different purposes. As you read through these purposes, you'll notice that they are characteristics of a learning health system: advancing care delivery, aligning payment with outcome, the conduct of research and public health, and the education of the public. The last phrase, leverage social services to promote and maintain community health, identifies the important integration of health information and health information technologies with other sectors of society.

The remaining two objectives for a learning health system address two new areas. First, objective number three states to support individuals' decisions to allow use of their data for societal benefit for research and public health while protecting individual privacy. And the fourth objective of a learning health system is to leverage data from populations to expand knowledge and promote scientific discoveries that advance the understanding of health, disease, and treatments.

We emphasize in objective number three the importance of engaging individuals in decisions about use of data for both research and public health, and doing that in a way that helps an individual make informed choices about protecting privacy. As you'll see in a few minutes in our strategies, there are many ways to approach this, and I'm sure there'll be comments on this particular objective. The leveraging data from populations to expand knowledge and promote scientific discovery is an objective that we view as an essential characteristic of a learning health system that addresses the data use not only for the purposes of delivering care, but also for the purposes of learning new ways, new understandings about health and healthcare.

Now the strategies are many, and if you have your document available, these strategies are summarized on page 12 and 13. I'm going to review them for you, and you'll have a chance to look at them with more time after this presentation is over. The strategies that we envision are strategies that could be undertaken in a fairly short period of time, and they include the following.

First, to continuously evaluate successes and lessons learned through health IT adoption and actively incorporate best practices into the health IT programs and services. A specific activity under this strategy is to provide mechanisms to assess and continuously improve electronic health record safety. Explore and develop electronic health record safety measures and reporting mechanisms as learning processes to improve the safety of electronic health records.

The second strategy should reward, showcase, and leverage industry best practices and innovative use of health IT to create an active community learning system that supports advancements in health promotions and treatment of all diseases in the United States. Within this, we anticipate that an important strategy will be make knowledge and technology accessible both to healthcare professionals and to consumers.

Our next strategy is to engage all levels of public and private sectors, including the international community, in coordinated activities to advance population health, which we see as including public health, biomedical research, quality improvement, and emergency preparedness. Specifically addressing this engagement by using common policies, standards, protocols, legal agreements, specifications, and services for data sharing and knowledge building. And the next strategy we advance is to stimulate and support innovations in care delivery, performance measurements, genomics, and comparative effectiveness through a health IT.



The last three strategies take on a broader sense. Strategy number five is to incorporate the global health dimension into the interoperability of the learning system infrastructure. Six, to harmonize meaningful use requirements with the dual needs of population health, that's clinical research, comparative effectiveness, and public health, and the learning system that delivers care to individuals, finally, through comprehensive education and communications campaign to promote a shared vision of a learning health system and the role of health IT to create it. These seven strategies, we believe, will be the first attempts to address the major objectives to create a learning health system, leveraging health information and health technologies.

Now we'll turn the discussion to the theme of meaningful use. Paul, I'll turn it back to you.

**Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO**

Actually, we'll open it up for public comments now. The questions from the public will go over, and the combination of the speakers and the workgroup members will answer them.

**Suniti Ponkshe - CEO, Ponkshe Consulting Services – Consultant to ONC**

Paul and Patti, this is Suniti. One question came online, which said about that we should end this on slide five where we have, in the results, we say inform patients. The question was we should say engage patients based upon what Patti just described. So while we are waiting for other public, I just wanted to present that.

**Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO**

While we're waiting for questions, let me point out two ways to download the documents we're speaking about. First of all, thanks to the public for a really vigorous response. We actually already maxed out on the number of folks who can participate on the Web at 500, and there were over 1,100 sign-ups, so many others can join the phone. But for the people who are on the Web, on the left side of your screen, there's an area, a green area labeled downloads, and the information that we're presenting, both the document, as well as the presentation slides are there that you can download. For the folks on the phone, in looking for the documents on the Web, it can be located under [healthit.hhs.gov](http://healthit.hhs.gov).

**Operator**

Our first question comes from Bryant Karras.

**Bryant Karras – Washington State Dept. of Health – Informatics Officer**

Yes. This is Bryant Karras from Washington State. I guess I looked on the [healthi.hss.gov](http://healthi.hss.gov), and I haven't been able to locate the documents on the blog. Have they been posted yet?

**Judy Sparrow – Office of the National Coordinator – Executive Director**

It's actually not on the blog. I think you need to go to the HIT Policy Committee page and then look under the strategic plan workgroup under current meeting, and you'll see the documents there.

**Bryant Karras – Washington State Dept. of Health – Informatics Officer**

Yes, they're not there yet.

**Judy Sparrow – Office of the National Coordinator – Executive Director**

They're not?

**Bryant Karras – Washington State Dept. of Health – Informatics Officer**

Just indications on how to participate.

**Judy Sparrow – Office of the National Coordinator – Executive Director**

Okay. One other strategy may be on the left-hand side of the ONC Web site, you'll see a federal advisory committee tab. If you click there, there's an at-a-glance calendar, and just click on that date.

**Bryant Karras – Washington State Dept. of Health – Informatics Officer**

Thank you.

**Operator**

Our next question comes from Nikolay Lipskiy.

**Nikolay Lipskiy – CDC – Standards and Interoperability Lead**

I'm Nikolay Lipskiy, CDC. I just want to ask to make more reasonable ... care for ... I'm talking about primary care prevention and secondary prevention. Specifically, it may be added to several areas. First, it may be added to objectives, and secondary, it may be added to objective number four, leveraging ... population. It may be added here. It also probably may be added to the goal of health information should facilitate leveraging of diagnosis, treatment, and preventions here. Thank you.

**Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO**

Thank you for your comment.

**Jodi Daniel – ONC – Director Office of Policy & Research**

Thank you very much.

**Operator**

We have next, Richard Eaton.

**Richard Eaton – Medical Imaging & Technology Alliance – Industry Manager**

First of all, I am from the Medical Imaging & Technology Alliance, and I want to thank the Office of the National Coordinator for holding this listening session today. Would this be an appropriate time or not to ask a general question about the strategic planning process at all? Can I have a general question? Is that acceptable?

**Patti Brennan – UW-Madison – Moehlman Bascom Professor**

Paul, I think that's your call.

**Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO**

About the process for creating the strategic plan?

**Richard Eaton – Medical Imaging & Technology Alliance – Industry Manager**

Yes, and also related to what the final product would look like.

**Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO**

Sure.

**Richard Eaton – Medical Imaging & Technology Alliance – Industry Manager**

Thank you. I've been reviewing the 2008 to 2012 strategic plan and the strategic plan update, and there are a great many strategies and objectives and principles listed. My question basically is whether the strategic plan that eventually emerges, I guess, this fall, is going to be tied to measurable goals, timelines, milestones, in order to provide kind of a plan of attack in terms of when certain steps will be taken, when

certain milestones or objectives should be achieved so that we can get from here to there in a measured, step-by-step way.

**Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO**

Thanks for your question. Jodi?

**Jodi Daniel – ONC – Director Office of Policy & Research**

Sure. That's a very good question. The workgroup has been focused on the goals, objectives, principles, and strategies. But, yes, the expectation is that our strategic plan would include measurable outcomes, milestones, etc. This is sort of the high level prioritization, the framework for us to be thinking about our strategic plan, but we will plan to flush that out and put some more meat on the bones and add in some of the milestones and measurable outcomes that we hope to achieve by a particular timeline, so yes.

**Operator**

We have our next question come from Michelle McGlynn.

**Michelle McGlynn – Siemens – Strategic Mgr., Government & Industry Affairs**

Yes. Thank you. I have a question on the strategies for the learning health system. Number six that you went through says harmonize the meaningful use requirements with the dual needs of population health and a learning system. Can you elaborate a bit more on what you mean by that?

**Patti Brennan – UW-Madison – Moehlman Bascom Professor**

Certainly I will start the comment, and I will invite the other members of the planning group to address this. The meaningful use requirements, as we'll go into more depth in the next presentation, focus quite a bit on insuring that care is available, if information is available for care, and that this information is available with proper protections in a manner that doesn't burden clinicians or patients excessively, etc. The focus is on the actual use of the information, and this particular strategy said we really need to go to the next level to understand that the meaningful use requirements may be right now most facilitated for the care delivery system, but there needs to be a way to also leverage that information in the process of care to public health concerns and to public health to knowledge building considerations.

There's a currently strong interest in comparative effectiveness, understanding the relative strengths and different clinical treatments that extends far beyond the care of any individual person. Our strategy number six here was designed to keep in perspective the idea that meaningful use needs to help both clinical care experiences, as well as creating the new knowledge for the next generation of clinical care providers. I'd like to now turn it to any of the other committee members want to comment on this.

**Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO**

I think that was a good rendition of what was behind that statement.

**Patti Brennan – UW-Madison – Moehlman Bascom Professor**

Thanks.

**Michelle McGlynn – Siemens – Strategic Mgr., Government & Industry Affairs**

Thank you.

**Operator**

Our next question comes from Charlene Underwood. Our next question comes from Gary Kolbeck.

**Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO**

...and then after this question, I'll read a question from the text submissions.

**Operator**

Okay.

**Gary Kolbeck – LodgeNet Healthcare – General Manager**

Thank you. This is Gary Kolbeck, and I appreciate the comment on the patient's active role in the participation more so than just the clinical side, so I appreciate that viewpoint, and also looking at the patient's overall experience and how they might learn in that environment.

Just a general question about patient interaction with the electronic medical record and the ways that they accomplish that. Are you guys going to be looking at different forms of technology and the ways we interact with patients through the use of that electronic information? Then secondly, is there anything that we should expect more specifically on the patient education, you know, diagnostic specific information because, you know, that was kind of in the HIT portion of it initially, and now it's been pulled somewhat out and re-committed? Can you just speak a little bit more about where patient education specifically might be going?

**Patti Brennan – UW-Madison – Moehlman Bascom Professor**

This is Patti Brennan, and I can speak a little bit more in-depth from the perspective of our research team here, not representing ONC in general. But the idea of finding the proper way to engage patients and to help them understand their own daily rhythms and health experiences is a subject of some demonstration projects, and I expect will be a continued target for new research. I know that the SHARP grants number three addresses cognitive decision-making and does specifically have some patient centered components to this.

I believe that the question you're asking is quite broad, though, and requires us to think about both informing patients about how to be good patients, and creating the proper information tools that help them understand their care options, understand care processes, what to anticipate and how to properly engage, as well as to insure that we understand them. I'm not quite familiar with what you're referring to about the patient education emphasis being changed. I know that in the meaningful use milestones, there are graduated an increasing engagement of patients with their own health data that will complement the other kinds of health information that needs to occur.

You will notice in our strategies and our objectives that we recognize that health information, becoming a good consumer of health information requires really attacking this problem at the K-12 level, as well as across the lifespan. So there are both technological solutions, as well as social change and social education that needs to happen. Jodi, if you want to comment from the ONC perspective on anything I may have stepped over.

**Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO**

Sure. I can interject—this is Paul Tang—a little bit. The questioner is asking about the meaningful use NPRM. The HIT Policy Committee did recommend that, as part of the patient engagement category, that patient specific educational materials be provided to the patient in the stage one criteria, and that did not appear in the meaningful use NPRM. The committee did come back and explicitly restate that, and that is believed that this is still both feasible and important in stage one. It remains to be seen whether it will end up in the final rule, but we still feel that's very important.

**Gary Kolbeck – LodgeNet Healthcare – General Manager**

Great. I appreciate that.

**Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO**

Thank you. There are a couple other, so by sort of arbitrariness in terms of how we divided some of the principle strategies and objectives in these various planks. There have been a number of questions dealing with educating the consumers, as this questioner asked about, and we'll address them in some of the other planks. For example, talking about how do we educate the consumer about the availability of HIT, what its benefits are. What are the barriers? That is going to be covered in meaningful use at least. Also, there was a question about educating the consumer about the privacy protection, and we have a special category dealing with privacy and security, and that's coming up as well, so we'll address those during that time.

**Operator**

Our next question comes from Alan Forsyth.

**Alan Forsyth**

Yes. Hello. Observational comparisons of outcomes of treatments compared with clinical trials is extremely subject to distorted results and providers of patients using the observational data that will be made available could end up with distorted perceptions of health outcomes and very biased evidence. This is the unintended consequence of a very good practice of using all the data available. But these often take some pretty sophisticated techniques. What, in particular, are you going to do to make sure that we don't end up with the kind of noise we get every day on the TV about this, you know, X is great for your health. X is terrible for your health. And then people just lose all confidence in any of the reporting.

**Patti Brennan – UW-Madison – Moehlman Bascom Professor**

This is Patti. I'll begin to address that by identifying that the strategic plan, as we're envisioning it, will incorporate work done through the Office of the National Coordinator, as well as related federal research bodies, government groups, and private sector initiatives. Your question is really important in how do we create a system that really learns, and there are a variety of pathways to learning. The comparative effectiveness agenda through AHRQ was one way that's designed to stimulate much more precision in the observational data, and that, complemented with experimental and translational approaches, should provide a composite picture.

We also recognize that there are many uncertainties inherent in healthcare. One of the critical activities for both consumers and for providers will be helping people to accurately appraise uncertainties and make decisions in light of those uncertainties where knowledge is known and where knowledge is not known, or where the outcomes of specific intervention may be known only in a probabilistic sense.

**Alan Forsyth**

So you're going to have some kind of structure or how does that work?

**Patti Brennan – UW-Madison – Moehlman Bascom Professor**

Well, I think....

**Alan Forsyth**

Suppose I'm a consumer, and I have a disease. Right now, I can look on the Internet and get all sorts of opinions, some of them interesting, some of them complete garbage, and I'm supposed to put that together and then go to my doctor and bug him about it. Now will I have a much larger resource and be able to look at the data myself somehow and come to my own conclusions? What kind of structure will be in place...?

**Patti Brennan – UW-Madison – Moehlman Bascom Professor**

I envision that Web based resources such as those that are provided now on comparative effectiveness work through CMS or through AHRQ will continue to be important to consumers. But there is, you correctly note that there is a huge amount of data, and much of it conflicting, so we have three sets of strategies that I think are going to be important for the future and trust that our plan is large enough to incorporate. One of them will be public education to create the informed competent data handler, and I've noticed some of the questions that have come through already.

Not everybody is going to be ready to do this in the same day. We have a generation to change. But we need to provide people with the skills to understand health data, and that, in part, takes us to resource number two, which is the skills to understand uncertainty in the information to weigh evidence, to make tradeoffs, and to clarify personal values. So some of the help, the consumer tools that will be provided will be less fact and content oriented and more process oriented tools.

Finally, tools that help patients and their providers engage in an efficient way without the stack of Web printouts that can terrify some clinicians or the patient too anxious to process new information after being given a complex diagnosis, we'd anticipate be enabled through these information technologies that might allow, for example, a more extended type of patient/clinician consultation over a variety of formats.

**Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO**

Let me ... I think this question really is extremely important. It's one thing that ... turn on the spigot for all of this, both information and exchange of information. It's another to figure out what the credibility of this information is, and what are the tools that consumers can use to assess that. Let me just also put this listening session in perspective. What we really want to do is hear issues like this that are very important that may not have been adequately addressed in the current draft, and I think we need to pay attention to and incorporate that kind of – incorporate that into the strategic framework that we recommend.

We are trying to answer some of the questions, but really it's not – we're not representing ONC, for example, so we won't have the ONC answer for you. But this is an example of something we do want to take into account, as we move forward with our recommendations, so I really appreciate....

**Alan Forsyth**

You might want to look at what happened when death rates for various hospitals were very first released.

**Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO**

Right.

**Alan Forsyth**

And the very best hospitals looked the worst, and everybody got all turned around backward.

**Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO**

Right.

**Alan Forsyth**

Without risk adjustment and things like that, so there is some history of this stuff first going sour, and then being turned around quite a bit.

**Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO**

Sure.

**Alan Forsyth**

Thank you.

**Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO**

Thank you for the input. By the way, all the questions and all the input are going to be archived and reviewed as far as input for the evolving draft. Thanks.

**Operator**

Our next comment comes from Richard Singerman.

**Richard Singerman – BioQuest – President**

Richard Singerman from the Singerman Group. Yes. On that very same theme of learning health systems, I was wondering. Have you folks looked at the works of someone like Peter Senge who really tried to have a synergy between the organizational learning on the one hand and the individual member, almost consumer, on the other? It was really a back and forth, and I think that could be very helpful, especially if you look at different populations ... and different cultures of adoption and innovation ... what are the overall cultural changes that need to support this.

**Patti Brennan – UW-Madison – Moehlman Bascom Professor**

I appreciate that recommendation. That's a really very important point. As we envision a learning health system, we're really thinking of systems of systems that will be experienced regionally and by people with different kinds of care issues or cultural patterns that may be in very different ways. And understanding what needs to be standardized, what need to be localized is going to be a very important part of any research agenda.

**Richard Singerman – BioQuest – President**

Great. Thank you very much.

**Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO**

Latanya, I have a question off the Web. What types of metrics have you considered from the patient side, that is, what is the criteria for success? How do we know we're doing well or what needs to improve? Excellent question. Another function for the listening session is if you can, one, your questions are archived, as I mentioned before. But, two, you can also send in further input. We, the meaningful use workgroup, are going to have a hearing on April 20<sup>th</sup>, this month, dealing with some of the criteria and getting input from testifiers, but also the public. So please feel free to submit your ideas on criteria we could use to assess how well we, as a system, are getting information in an effective way to patients that they can use in enhancing their own health. We're also open to that kind of concrete input as well.

**Operator**

Our next question is from Charlene Underwood.

**Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs**

Paul, just a question relative to the broader strategic plan and framework is how does this framework fit into kind of the context of broader national health priorities? Is there a relationship? If so, how would we see that, or is that something that you'll address later today? Thank you.

**Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO**

We'll address it in the next component of meaningful use. I think we have time for one more question.

**Operator**

We have Pamela Coach. We have Carol Wright. Okay. There are no comments or questions.

**Patti Brennan – UW-Madison – Moehlman Bascom Professor**

I want to thank everyone for their input and for the very rich set of comments related to the learning health system. It has certainly provided a number of stimulating ideas for the committee to think about and incorporate, and we'll look forward to continued dialog on the blog. Thank you.

**Jodi Daniel – ONC – Director Office of Policy & Research**

This is Jodi Daniel. I just want to say that we did get a lot of comments on the Web that we didn't – we brought up some of them, but all of the presenters and all of the workgroup members will make available these comments to folks, so they have them, even if we didn't actually address them live.

**Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO**

Thank you. We'll proceed with the next plank, and this has to do with the meaningful use of health IT. The goal, as you know, is to produce systems, implement systems, but also to effectively use them to further the health goals of the individuals and the population at large. And you also are probably aware that the HIT policy committee recommended a framework that was really explicitly targeting clinical or health goals.

Four of them have to do with, for example, the first one is improving the quality of patient safety, efficiency of healthcare, and to reduce the disparities. The second is to engage patients and families in their own health. The third is to improve care coordination. The fourth is to improve public and population health. The final one, which we consider foundational, is to improve the privacy, protect the privacy and improve security of the health systems that contain this information.

The principles that were used to develop this framework by the meaningful use workgroup include the following. One is that we did want to focus on important national health priorities. Now it's not the role of the HIT Policy Committee to come up with those priorities, but there are other groups. The administration may have certain health priorities. The secretary may have health priorities. And many other groups that operate in the consensus fashion may develop health priorities when they're explicitly set up to do so.

One of those groups is a group called the National Priorities Partnership. It's hosted by the National Quality Forum, and it is made up by a multi-stakeholder group that explicitly set out to identify contemporary health priorities for the country. So we adopted those four clinical or health priorities that I listed really as sort of a massaging of the ones that came out of this National Priorities Partnership group. The principle is that we would use the contemporary health issues and focus our attention on those.

The second principle is through HITECH and through, of course, the usual powers that the federal and state governments have. There are a number of policy levers, and there are a number of new authorities and money that the Recovery Act provided to help encourage the development of, the implementation, and the meaningful use of these systems, and we should use the full gamut of policy leverage to affect that kind of change.

The third is something we're, I think, especially proud of is not to focus only on the software and the systems that benefit the professional healthcare team, but also to include, as a first-class participant, the patient and the important caregivers that are involved in their care. You'll see that as the meaningful use criteria, but that comes out of this principle.

Now it became very obvious to everybody involved in this effort to try to come up with not only the framework, but some of the accompanying policies that it's pretty hard to apply a policy to everyone, for



example, to everyone in the country and every organization. Yet, we've try to do that and make it apply to the broad array of professionals out there and the patients and consumers out there, and balance that with the need of the sense of urgency that the Medicare trust fund is currently projected to go bankrupt by 2017, so this does not allow a whole lot of time. If it might take 20 years to really do this for the country, we just don't have that, so we really have the sense of urgency of making it happen as quickly as possible even though we realize that is very ambitious and that the whole country can't ... the time goals that we set forward, but that's the tradeoff that we did, we undertook throughout the entire process.

The fifth is that we wanted to try to establish through the staging process, a glide path that would sort of smoothly go from picking up the ball from square one to getting to the end goal in the fairly near term and wanted not to avoid it as much as possible, recommending criteria that would lead one organization into a dead end.

The sixth is not everyone has the same access to resources, whether that's the capital or the workforce or the expertise in this area, so we want to prioritize the country's resources to provide ... areas that have the greatest need. For example, you'll see that the REC center is targeted mainly to the smaller providers that don't have the same access to capital and expertise that the larger providers do.

We came up with a set of objectives. One matches the President's goal, which is by 2014 to have the country's health data contained in these electronic health record systems. As I mentioned, it's pretty hard. It's going to be very hard to reach that objective, having all data there, but we're trying as hard as we can in terms of setting up these milestones. That means capturing, managing, and meaningfully using the health information to improve the health and healthcare for all.

The second objective is to leverage the public sector resources and all the policy levers, as well as in conjunction with the private sector based on the adoption of proven HIT that accomplishes the health outcome goals.

The third is to target them towards the national health priority issues. Now let's say there are 50, just making that number up. We had a choice of either establishing 500 different criteria to try to address these important health objectives, or come up with one that if you are able to carry this out from start to finish, probably you have a system that can deal with the 500. So we chose the exemplar approach, which says if you can provide preventive health for minors, if you can provide evidence-based alerts to the provider and the patient, then you've probably done a lot of work in characterizing the clinical goals or the clinical guidelines, program that into your computer, having it show up in front of the people on the health team, which includes the patient, and having it in an effective way so that they can act on it. That's what we meant by an exemplar approach rather than enumerating, let's say, 500 ... different functional features.

The fourth objective is to make sure that we can get health information to all the people who need to use this information in a secure and protected way. That includes the patients, the consumers, and all participants on the healthcare professional team so that they can have access to the information they need, and that's not just data, but it's also the knowledge such as the evidence, so they can make appropriate decisions.

The fifth objective is to advance and promote HIT, and this addresses some of the questions we had in the earlier session. How can patients use this information to become more engaged in their own health and more active in the plan, in the action plan for themselves? That's not just for sick care, but it also includes wellness and health maintenance. How can they become a more active participant in their own health and healthcare? How can they make shared decisions along with their professional teams?

Six is how do we improve the efficiency of the healthcare system? Clearly there's a lot of waste in the system, and we need to find a way to, one, make the best possible decision, but also to eliminate the decisions that aren't appropriate or not efficient, and that is something we want to do for all members of the health team, including the patients.

We had a set of strategies, and I'll just sort of outline the strategies we've come up with. They're obviously in the document. The first is how do we maintain and update a meaningful roadmap of how you get from here to there? Most of the country is starting from square one, and how do we, in a progressive way, get them to a full implementation of a system that really is going to enhance their care? Well, that means identifying the national health priorities, as we mentioned earlier.

It means having a way of assessing where we, as a country, stand at any moment in time, and what's the progress towards the goals? If it's too slow, we may want to alter future criteria. If the country is doing better than expected, we may want to modify things. We want to direct both the policies and the resources in a way that's going to get the country from square one to our meaningful use as quickly as possible.

Where we find barriers, you know, where we uncover barriers and learn more about them, we need to design strategies that would overcome those barriers. We want to insure the participation ... of all members of the health team. We focused a lot on primary care providers. We focused on the smaller providers and rural and safety net. We focus on the consumers, and we have a special need to deal with those providers who are not part of the HITECH Act. Some of the folks that are excluded, there's some legislative approaches to perhaps including them or some folks who want them included. But there are still folks. Not everyone is going to be included. How can we make sure that everyone, to draw the analogy with the fax machine, has a fax so that we can communicate with everyone? We've got to design programs that address that need.

And I'll interject that, again, the \$27 billion in incentives may be going to a specified, you know, a target population of providers, but there are still a lot of programs that are influencing everyone. For example, establishing health information exchange organizations. Everyone, whether you participate in the Medicare incentive, for example, is going to benefit from the work that's done in the HIE world, as well as privacy and security. There are just a number of collateral benefits that occur just throughout the many ONC programs.

We mentioned before, the workforce is out there, either to implement or use these systems just isn't sufficient in number. And so there are programs that address that need for workforce training, and there may be other ways to help educate the folks and train them to accomplish this task. Then again, going back to how we work with consumers. Clearly there's not been enough education to help consumers understand what can their role be, and how can they access credible information? We need to change that.

And I know ONC is very interested in that, and that's everything from formal programs to public service announcements. You can see how the public service agencies have changed whether we use seatbelts or not or car seats. We need to almost go out with that kind of level of effort to make sure that consumers are aware of the tools that will become available to them and how to use them effectively.

EHR products, as they exist now, they could be better. They're haven't reached their maximum and optimal use, so we need both the intense motivation and the resources to continuously improve their

usability and the way that we can achieve the value from their use. That needs to be explicitly addressed. At least that's what the workgroup thinks as well.

With that, those are sort of overviews for some of the strategies we currently have in the document. We're open to your questions, suggestions, and input.

**W**

I noticed that there are four phone questions, if you want to get started with those.

**Operator**

Our first question comes from Carol Wright. Please proceed with your comment and your organizational affiliation, please.

**Carol Wright – FAIP – IT Professional**

Hello. My name is Carol Wright. I'm an IT professional from FAIP. My comment, it does affect meaningful use, but it's specifically about the learning healthcare system strategies three and five, which seem to play into an international dimension of sharing data. I just looked quickly at the privacy section, and I think it affects meaningful use as well, and would just query the group if they feel the security strategies or principles are adequate to address national security threats when it comes to sharing this data internationally. I see the privacy strategy needs to be a very national focused one, and the principle seems to be a nationwide security framework, but you have themes here that seem to suggest data would be shared internationally and for the benefit of global health, which are good outcomes, but it will, you know, increase your data security requirements quite a bit, and I just wanted to throw it out there for your consideration.

**Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO**

Let me try to answer that in a couple ways. One is certainly Deven is going to cover this more on the privacy and security area. Two, just to explain a little bit of what we meant by some of these objectives and strategies under a learning health system. We just wanted to make sure, and I think you alluded to that, that we don't have a silo in terms of focusing only on the United States when global health threats have just become part of our everyday life, whether you think of H1N1, avian flu ... illnesses. All kinds of things mean that because we transmit ourselves in planes, etc. in different parts of the world, we are also bringing in and participating in global health and global health threats.

Our intent there wasn't that any individual, certainly any individually identifiable information would be transmitted throughout the world. But we would share public health data, as well as public health learning to improve the health of our country, as well as the world. That was what was meant, and we appreciate your thought, you know, the implications, potential implications on privacy and security, but it was mainly in the learning framework that we meant that to be.

**Carol Wright – FAIP – IT Professional**

I do appreciate that objective. I just think that, from a data perspective, the security requirements will definitely increase, even under that kind of public learning objective.

**Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO**

That's a fair comment.

**Operator**

Our next question comes from Reginald Odem.

**Reginald Odem – RAM NetSoftware, Inc.**

Hello. This is Reggie Odem with RAM NetSoftware, Inc. We're a vendor of EHR and EMR. With the first stage of or the first level of stage one rapidly approaching as far as compliance issues, there seems to be a lot of back and forth regarding the metrics pertaining to there by 23 to 25 conditions, which the EH and the EP eligible professionals, eligible hospitals would have to adhere to in order just to pass stage one. The question is, there were recently recommendations made to Secretary Sebelius regarding a relaxation of some of those metrics to, I guess, avoid the all or nothing conditions, which are currently on the table. Does it appear that that's going to be relaxed in time in order for there to be, shall we say, a consistent flow, which will obviously be necessary once everything shows up?

**Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO**

Thanks for the question. Clearly, at the stage that you're referring to, CMS and ONC are working now to finalize the rule, incorporating all the input they've had from all the people who have written in, people who have testified, and presumably letters like are coming from Congress. The advisory committee and not even ONC knows at this point what's going to be in the final rule. What CMS has said before was that they were targeting late spring for having the final rule out.

I'll remind people that, yes, 2011 is closed, but people can qualify. Organizations can qualify up to the last quarter of 2012 and still meet the highest payment amounts for stage one. One is you don't have to make it in 2011. Two, ONC and CMS are working as quickly as they possibly can under the circumstances to get the final rule out, and that'll give us all guidance on how to meet the criteria.

**Reginald Odem – RAM NetSoftware, Inc.**

Thank you for that. In addition to there being the extended time period, per se, through 2012, another proposal on the table is that since stage two would be right around the corner as far as taking it to that limit of 2012, the software that would have to be incorporated into the practice or adopted by the practice would then have to be to the degree of being able to accept stage two applications while also having stage one on the table, which brings up – it's almost like a snowball effect. When you get behind the eight ball, there's a lot of catching up that has to be done also on both sides, the vendor, as well as the practice. That's still in a volatile type of position as well. Do you see any problems there?

**Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO**

Plenty. Many people have pointed out this quandary as well, and it's a legitimate comment. As you know, many of the dates are actually written into the HITECH Act, so some of the urgency is there by design. And, as they've pointed out, it's a balancing act for us all. In recognition of the challenges that you just enumerated, which are fair ones, we are trying to—we, now the meaningful use workgroup and the HIT Policy Committee—are trying to get draft recommendations or at least signals to the industry of how we are trying to progress on stages two and three criteria to try to give the industry and the organizations enough warning or at least signal on where we're headed with this roadmap. So we are trying to address that. We can't come out.

Obviously CMS can't, and the policy committee can't come out with "final recommendations" or "final rules" too early because, on the one side, you want to also incorporate what you're learning about how people are meeting stage one. So you're sort of between a rock and a hard place. But yet, we want to be able to signal the direction we're going to give everybody as much advanced warning as possible. So we certainly appreciate the quandary and the challenges that you mention there, and we're trying our best to try to address it at least.

**Jodi Daniel – ONC – Director Office of Policy & Research**

Paul, can I just jump in with one comment?

**Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO**

Yes.

**Jodi Daniel – ONC – Director Office of Policy & Research**

I just want to – this is sort of a ground rule. Since we are in active rulemaking, I just want to encourage people to focus on the strategic framework that we have in front of us. Granted, we have a team on meaningful use, so that line blurs a little bit, but we really can't accept comments at this point on the regulations. We are in the process of reviewing the comments we've gotten from the federal advisory committees, as well as from the public, and we're working through all of those, and I would encourage folks to focus on the strategies and strategic framework as opposed to have discussions about the regulations themselves since we really are limited in what we do say about that.

**Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO**

Excellent comment. Excellent comment.

**Reginald Odem – RAM NetSoftware, Inc.**

Thank you.

**Operator**

Our next question comes from Gary Kolbeck.

**Gary Kolbeck – LodgeNet Healthcare – General Manager**

Yes. This is Gary Kolbeck, and I appreciate your comment earlier that maybe the learning path wasn't as much as appropriate for the patient education and patient engagement as this one. I come from LodgeNet Healthcare, also representing Interactive Television Services, so it's a better way to try to engage patients using a two-way interactive tool that they're already comfortable with. That's kind of the basis for some of the questions that I asked.

When I look at this, though, I see the meaningful use category. Do you see it breaking into two branches: one being a meaningful way for healthcare organizations to use more data that they have available for patients throughout the care process? And then also, an area where the patients themselves have more of the input into what is meaningful to them because they might be completely different? Obviously we're trying to drive better outcomes, but it's not necessarily technology for technology, but it's finding a way to use technology to better engage and communicate with one another.

**Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO**

I think your point is well taken. I'll point out one hook about where we have to be grounded is this, so this category of patient and family engagement does apply to meaningful use of HIT, and so the incentive program goes to the provider side, whether it's practitioners or the hospital. For example, if there is an application that is only out in the consumer space unrelated to the information that's either generated or consumed on the provider side, it wouldn't necessarily tie into the meaningful use program for the HIT incentive program. Do you see what I'm saying?

**Gary Kolbeck – LodgeNet Healthcare – General Manager**

Yes. I do understand.

**Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO**

I understand your point, but we do have this one connection.

**Gary Kolbeck – LodgeNet Healthcare – General Manager**

Yes, I think it's more about the point that says if I know the diagnosis of the patient or through a TV as an underutilized communication tool, I can query people to find out how they best learn information and provide a lot of that information in a video friendly environment, which obviously a lot more comprehension it would have through video, so it's one of the ways to drive that. It's one way to engage.

But we also can engage specifically with – the patient surveys that we've done say that they want more information about the environment in the hospital surroundings that they're unfamiliar with, information about their illness and their diagnostics, their care team and the people that are going to be taking care of them, and then their return to wellness plan. Some of that information obviously is driven by their illness, who is assigned to them as a care team, and those different elements. Do you see that correlating between the two?

**Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO**

I think it can, and one of the ways, you might recall, we talked about the meaningful use incentive program applies to these prescribed providers and organizations. But as a strategy, we are proposing that ONC come up with programs that address the needs outside of that incentive program. Do you see what I'm saying?

**Gary Kolbeck – LodgeNet Healthcare – General Manager**

Yes, I do.

**Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO**

Perhaps what you're describing are one of the beneficiaries of that kind of program.

**Gary Kolbeck – LodgeNet Healthcare – General Manager**

Absolutely.

**Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO**

Clearly, if we get information in electronic form, in a codified way, and can exchange it in a secure and private way, a program like you described could also benefit.

**Gary Kolbeck – LodgeNet Healthcare – General Manager**

Thank you. I appreciate it.

**Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO**

Thank you.

**Operator**

Our next comment comes from Zachary Morgan.

**Zachary Morgan – MEPS Corporation**

Yes. My name is Zachary Morgan. I'm with the MEPS Corporation. My comment is in regards to the test of meaningful use and so forth. As you know, as we try to achieve continuity of care and better outcomes, we are certainly wanting to insure that patients go throughout the continuum of care.

My question is, are we looking at bringing other providers into the fold such as infusion therapy companies, home health agencies, and durable medical equipment companies and so forth? And my second question is in relationship to, is there any discussion about signing a universal code to follow the patient throughout the continuum of care?

**Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO**

Let me try to answer in the context of a strategic plan. One is what about other people participating. What other people in the organization will be participating...?

**Zachary Morgan – MEPS Corporation**

Are they eligible or not?

**Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO**

Correct.

**Zachary Morgan – MEPS Corporation**

Those people that fall outside of the eligible ... hospitals of eligible providers such as home health agencies and infusion therapy companies and durable medical equipment companies because, if we're going to get true efficiency, we have to follow those patients throughout the continuum of care. I was wondering, has there been any discussion from the strategic level related to bringing them into the fold.

**Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO**

Yes. It's similar to the comment I made earlier. There is a specific recommendation in the current draft to ONC that its programs, make sure that it encompass all the folks and organizations that participate in the health and care of individuals in the population. That means, in addition to the folks who are formally designated as beneficiaries or potential beneficiaries under the HIT meaningful use program of Medicare and Medicaid. Although many of the providers you listed, the ... providers, home health are not included. They, we think, can benefit from the infrastructure that is laid to capture and manage digital health information. I think the groups you enumerated would benefit from this.

**Zachary Morgan – MEPS Corporation**

The second question related to our universal ID for patients. Has there been any discussion at the strategic level related to being able to follow that patient throughout the continuum of care and insure that every vendor, every provider is not giving out different IDs for those patients, which causes a fragment...?

**Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO**

Yes, that's a problem that has been well recognized. As you may know that HIPAA actually required a universal health identifier. Congress subsequently stopped discussion on that, and at this point, still there's no funding to continue that discussion. There are, however, a number of groups that are interested in picking this up again because, as you point out, lack of one may actually be interfering not only with care and safety, but also the learning health system aspect. It's clearly something we've heard. Thank you.

**Zachary Morgan – MEPS Corporation**

Okay.

**Operator**

Our next question comes from Jerald Leisy.

**Jerald Leisy – Capella University – Ph.D. Student**

Yes. My name is Gerald ... Ph.D. student with Capella University. The question that I wanted to ask is regarding the HITECH initiative, which really represents a significant, large-scale, multidimensional change to both the technical and the human systems. The learning health system that was discussed

previously, I think, is a great move toward nurturing an innovative culture that can really support meaningful, long-term, adoption of health IT.

However, another critical element that should also be considered is the creation of readiness for change, which really involves many human factors. I think readiness for change must be strategic, meaning it must be created early enough to prevent resistance and improve adoption in a meaningful way.

**Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO**

This is an extraordinarily important point. Thank you. I think readiness for change is probably one of the hardest things to accomplish. I'm not recalling that we addressed this specifically. We may allude to this, but I think the benefit of your input would cause us to go back and make sure that we target that as something that the country and, perhaps through some of the efforts of ONC, help us address. I can think of an existing program, let's say the REC centers. The regional extension centers certainly will, in the course of trying to help particularly smaller providers get through the implementation of these EHRs and their meaningful use, clearly will have to address change, change management, and the readiness of change. But the notion of having formal ways of getting this kind of information out to everyone is a good idea.

**Jerald Leisy – Capella University – Ph.D. Student**

Yes. Thank you very much. The whole idea is to produce a virtuous cycle in preparation for the health IT implementation that eventually we have to.... Thank you very much.

**Operator**

Our next question comes from Robert Jarrin.

**Robert Jarrin – QaulComm, Inc. – Director, Government Affairs**

Sure. Thank you. Robert Jarrin with QaulComm, Inc. First and foremost, thank you very much for undertaking this enormous task, you know, meaningful use, and the rest of it has been very, very difficult and a long process, so thank you. Having said that, one of the issues that I'd like to flag for the strategic framework is to really focus on expanding the definition of meaningful use. I know that there's an NPRM, but beyond that in the way of a strategy. I really feel that they should promote not only the systems that govern EHRs, but also the adoption and the use of interoperable health information technologies such as devices, sensors, products because those are really the ones that are going to be capturing and driving an enormity of health information data into the electronic health record systems.

My fear is that by solely focusing on EHRs and not how the data will actually be populated and sent forward would really perpetuate a culture of manual data input. You know, the inaccuracies and all of the writing on the back of the hands and on the sleeves, etc., which ultimately don't help the patient, and that's, at the end of the day, the most important part of this entire system.

**Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO**

Fair comment. Again, this is not on the meaningful use criteria per se, this listening session, but I can say that we are having hearings later this month on April 20<sup>th</sup> trying to open up the whole notion of what's involved in engaging patients and families. Many of the instruments and sensors and products you mentioned play a role in that in terms of opening up beyond the so called electronic health record system to incorporate those kinds of data. That's something we want to drill down on and figure out how do we incorporate that kind of data as part of the whole health record and as part of meaningful use and look towards writing some criteria that would help uncover and take advantage to leverage those kinds of data.

**Robert Jarrin – QaulComm, Inc. – Director, Government Affairs**



Thank you.

**Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO**

I'm going to read one from the Web. Dr. Blumenthal and others at HHS have noted that the best time to inform decisions is at the point of care, and it's central to better healthcare. The framework never explicitly addresses clinical decision support. Can it more explicitly address that? We actually do have – well, I tried to get away from the criteria, but just address the specific question.

We actually do have meaningful use criteria. In fact, in the stage one, it requires use of clinical decision rules around five topics. At least the NPRM had that at the provider's choice. It is an explicit part. It's clearly baked into the whole value of computer based physician order entry. So clearly that's what the group recognized as a big part of the value proposition for electronic health records, as well as personal health records, and so I think it is addressed.

Is there another one from the--? Okay. Let's see. There's one that says all this ... recommend that the committee spend time before the final framework is released to revisit the broad area of patient safety one final time. I think that's good input. We want to make sure we cover all the bases. We subscribe to the six aims the IOM proposed. That's the ultimate goal. One intermediary is achieving health outcomes, better health outcomes ... individual condition, and we certainly want to make sure that patient safety plays a primary role as part of the objectives for meaningful use....

**Jodi Daniel – ONC – Director Office of Policy & Research**

Paul, if I can just jump in, this is Jodi Daniel.

**Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO**

Yes.

**Jodi Daniel – ONC – Director Office of Policy & Research**

That in theme two, which we are going to go to right now, the policy and technical infrastructure, there is in fact a strategy focusing on patient safety related to health IT as well, so it's covered in the next section as well.

**Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO**

Perfect. Once again, I want to thank everyone for their input. We did archive not only the things that have been verbally expressed, but all of the questions that have been written in. The workgroup will go through those, as we come up with our final recommendations to ONC. We'll be revising our draft document. We'll be presenting that to the full HIT policy committee and coming up with a final document that ends up going to ONC in May.

The next topic is policy and technology infrastructure.

**Paul Eggerman – eScription – CEO**

Thank you, Dr. Tang. This is Paul Eggerman speaking to you from Boston, and I will take you through this topic. The title of the topic is Policy and Technology Infrastructure, which certainly seems like quite a mouthful. The reason it's called that as opposed to just technology was we wanted to make it clear that the federal government is not trying to create technology or even to endorse specific technology. The way that we intend to operate is by establishing a series of policies or standards or certification criteria or specifications. It's basically an infrastructure or a framework.

On the screen, you see the goals that we have established for this topic, and it says to enable management and secure exchange of electronic health information to meet the goals of meaningful use and ... health system. I want to emphasize that very first word "enable". Basically the way we see this entire process working is that what we're trying to do is say that technology enables change, but it's not the change. We are trying to be the mechanism that enables the kinds of changes that Dr. Tang and Patti Brennan just spoke about, but we aren't the change ourselves, and that's why this topic is presented after the whole meaningful use topic, after we discuss what our ultimate goals are.

In support of this goal, we have five principles and four objectives. The first principle that you see on your screen, it says policies and technical specifications required, promoted by the government should, at a minimum, allow providers to achieve meaningful use. You say minimum. What else is this supposed to do besides meaningful use? There are at least two other broad categories. One is support privacy and security, which we'll talk about in a minute. And the second is interoperability or information exchange, which I'm going to talk about a little bit.

If you look at the second principle, it talks about the information. It talks about market innovation, leveraging market innovation. What we're trying to do here is to make it clear that fundamentally we want to take advantage of the significant innovations that are determined in information systems and communications technology.

The third principle states that basically this health information exchange should enable all participants in the exchange to contribute toward meaningful use. In this first slide, I want to emphasize the expression all participants actually relates quite well to the question that was just asked about meaningful use, about home health organizations. The concept of all participants, of course, includes patients and physicians, but it includes home health organizations. It includes pharmacies. It includes state public health organizations. It includes researchers. There's a lot of varied participants that need to be included, and so we see ourselves establishing an infrastructure that all of those participants can participate in.

The fourth fundamental principle is to keep things as simple as possible and to design them for implementation by all participants. That's sort of an egalitarian concept. And the final of the five principles is number five is, it says, policy to technical certifications or technical specifications should make possible and promote increased patient engagement and access. And so we're calling out specifically patient engagement and access for a couple of reasons.

One is entirely to be consistent with the comments that were just made about a patient centered approach to meaningful use, a patient centered approach to a learning healthcare system. But we are also calling this out too because, in my opinion, if you look in the last 15, 20 years, and you look at technical innovations that have ... this country. For the most part, they've been driven by consumers, and so what we are hoping for is that similarly patients and consumers will eventually help drive what is going on with health information technology. Those are the five principles. In support of that, we have four basic objectives.

The first one, as you see listed here, is to establish, again, this concept of standards, implementation specifications, certification criteria, in other words, a group of policies. But the keyword here is to incrementally enhance interoperability and functionality, the utility of these systems, so this concept is incremental enhancement. Fundamentally, the reason we have to do incremental analysis is sort of state the obvious is to accomplish what we want to accomplish really isn't a technical challenge. It's really a people challenge.

The fundamental challenge is how do we sort of move forward as a nation and incrementally improve these systems at a rate that can be done in a safe and reasonable manner. Yet the second objective that's very important that we see here is to encourage and facilitate the development of market sustainable mechanisms. I want to emphasize market sustainable mechanism that are related to health information exchange. The objective is to be sure that even though the government is spending a fair amount of effort and resources in setting up these various information exchange organizations the various states, the objective is that eventually those can all be – the methodology for information exchange would be such that it would be entirely sustained privately.

The third objective is to increase market confidence in EHRs and other HIT products. This is a very important concept. Fundamentally, we recognize that there's a range of views in the public about these systems, and just as there's a range of views in the public about technology, and some people think that an electronic health record is absolutely terrific and is going to be the solution to every problem that exists in healthcare, and there are some people who think these things are absolutely terrible, and it's like a huge waste of time and money, and there's a lot of people in the middle who either don't know or are interested and skeptical, and so there is a clear objective to increase the market confidence in these systems.

And the final objective is, besides doing ... nationwide capability for health information exchange, and obviously to enable meaningful use in the learning health system. When we talk about nationwide capability, we are talking about the entire country, and the objective that Paul Tang talked about that every American would have an electronic health record by 2014. But this also relates to every segment of the country.

We need to make sure that our process includes rural healthcare. It, for example, includes safety net institutions that tend to be urban that could include neighborhood health centers. It includes solo practitioners, small physician groups, large institutions. That's also one of the objectives.

Now in support of those objectives, if you look at the framework documents, there's actually six strategies listed, and I'm not going to drag you through each one of the strategies. I think people can read them if they want. There are strategies around certification. There's a clear strategy around the concept of patient safety. When we talk about patient safety in this context, it's the context of unanticipated or undesired patient safety impacts from implementation in these systems.

There are some interesting footnotes, a couple of interesting footnotes in the strategy section, one on the subject of semantic interoperability in terms of the direction that we're going, and I would encourage you to read through that material. But having gone through this ... brief ... the purpose of this discussion or this session is to listen to you, the public, and so I am very interested in hearing people's reactions to this thing and any comments or questions. Can we open the discussion for comments?

**Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO**

Thanks, Paul.

**Paul Eggerman – eScription – CEO**

Actually, I see somebody typed one in, if I could read it. Will infrastructure be built specifically for patient health records, PHI? Actually, that's a very interesting question, and it's a question for which we don't know the answer to yet. We want to have – we want to facilitate patient access, but so far we haven't really touched on the PHR, and so if you think we should ... that's what the question suggests, I think that would be a good observation.

**Jodi Daniel – ONC – Director Office of Policy & Research**

This is Jodi Daniel. Strategy two does talk about assessing and adopting standards of implementation specifications and certification criteria to enhance interoperability, functionality, utility, and security of health IT. It specifically includes PHRs in that, and I believe that the workgroup did discuss that particularly with that in mind that it shouldn't just be focused on EHRs, but also looking at PHRs, mobile health, home monitoring, etc.

**Paul Eggerman – eScription – CEO**

Thank you very much, Jodi, for clarifying that. Also, I see there's another online question that somebody typed in. I guess the technology discussion gets the online questions. Will hazard analyses ... a required part of the software development process? I guess my response to that is that's also an excellent question, and I suspect I know where the questioner is coming from in asking that question. I actually don't know whether or not it will be required, but if the questioner thinks that it should be required, I think that would be a reasonable viewpoint, and you ought to send that comment in.

**Jodi Daniel – ONC – Director Office of Policy & Research**

I'd like to just highlight also that the certification adoption workgroup is taking on the issue of patient safety and health IT right now, so if somebody is particularly interested in this topic, you might want to look at the next workgroup meeting for certification adoption workgroup and make specific comments since they will be coming up with specific recommendations on patient safety and health IT in the very near future.

**Paul Eggerman – eScription – CEO**

Are there any other questions?

**Operator**

We have a question from the line. We have Michelle McGlynn.

**Michelle McGlynn – Siemens – Strategic Mgr., Government & Industry Affairs**

Yes. This is Michelle McGlynn from Siemens. My question is about standards harmonization and implementation specifications that you talk about in the strategies. You mentioned that this plan covers the timeline of 2011 to 2015, which would account for stage two and stage three meaningful use. Leading up to this point, we had HITSP and the standards committee and the development of the criteria. They all came together to feed into stage one standards and specifications and criteria, and I understand there's been some processes for some sort of future standards organization.

My question is, what will that look like moving forward as part of this plan? And then I guess a secondary question is how will the public and stakeholders engage in that process?

**Paul Eggerman – eScription – CEO**

Thank you, Michelle. Those are great questions. In the context of the strategic framework, I guess my comment is, I don't know. I don't have a specific roadmap to tell you how that will look. I suspect that the standards committee, at least for the time period you talked about for the next few years through 2015, play a major role in that process.

And certainly the clear direction from David Blumenthal is that everything that we do needs to be done in an open and transparent manner, and so that will also occur. The various components, whether it's HITSP or other organizations involved, I don't know. I suspect, as we get further down the line and things get a little bit larger, there may be other organizations that also get involved in that process.

**Michelle McGlynn – Siemens – Strategic Mgr., Government & Industry Affairs**

Thank you.

**Paul Eggerman – eScription – CEO**

Thank you, Michelle. Good comment.

**Operator**

Our next question comes from Reggie Odem.

**Reginald Odem – RAM NetSoftware, Inc.**

It's Reggie Odem again with RAM NetSoftware. Just a comment regarding the confidence as it pertains to EHRs, EMRs. It is more than a functionality issue as far as specific software that ... being able to do all of the above and then some. It comes down to managing of that particular software in order to have it do or meet compliance. That's going to be, in my opinion, that will be one of the main focuses that will come into being just through the process of incorporating HIT, specifically EHR, EMR because, as long as there are conditions, which there need be, the software is only going to address the basic premises of operational from an operational standpoint. There will have to be some managing, and that will be, I believe, the key of the future. Thank you.

**Paul Eggerman – eScription – CEO**

Thank you, Reggie. Excellent comments. Very helpful. I'm also looking at – reading one of the online questions, as it came in. It says how/who will we insure multiple EHRs, PHRs that contain my health records will be integrated into an integrated HIE, EHR, PHR. Right now, every providing clinical system is different, and most patients somehow ... reside across multiple medical systems.

It's really an excellent question. You have all these different systems, and so how do you bring it all together? How do you bring it all together, not only for the purpose of what was just said here, but also from the standpoint of researchers trying to understand or doing effectiveness analysis? I think the way that we are approaching that issue is, it is described, actually, in one of the strategies is to somehow prioritize the data that needs to be exchanged between or among organizations and establish some policies around that so that as you prioritize that data, you can also ... define, as was done in the IRF. What are the vocabularies that need, standard vocabularies that need to be used to exchange that information?

This issue that the questioner raised is the key issue, is an area that, as we move from where we are right now to a point of getting this concept of semantic interoperability, this is an issue that we're going to have to work more and more on. It's a great question.

**Operator**

We have a question from Jerald Leisy.

**Jerald Leisy – Capella University – Ph.D. Student**

Yes. This is Jerald Leisy, and I'm a Ph.D. student with Capella, and the question that I have is regarding objective one. In addition to interoperability functionality, utility, and security of HIT that you mentioned, should the standard also require the infrastructure to be reliable? Meaning, will the infrastructure have enough bandwidth to prevent bottlenecks and errors so that communication between the databases can occur seamlessly. Another question is that will the infrastructure also be survivable in a catastrophic event?

**Paul Eggerman – eScription – CEO**

Those are terrific questions. It's not surprising to me that you are a Ph.D. student with questions like that. You asked about reliability, bandwidth, and survivability. Those are the issues. And in response, I would say what we're saying in this framework is that the government is really not providing the infrastructure itself. It should be providing policies and methodologies and standards to use existing infrastructures, so the concept that fundamentally the Internet is most likely to be sort of the backbone, although that's not necessarily a good word to use, of the entire structure. And so that is how we envision this all happening, so ... reliability, bandwidth, and survivability.

The issue is to what extent the Internet is able to withstand all those three questions. It's certainly appropriate things from a strategic standpoint that we should be looking at, so I appreciate the question. Perhaps we should make sure that we write that down to make sure that that is something that we're constantly looking at.

**Jerald Leisy – Capella University – Ph.D. Student**

Thank you.

**Paul Egerman – eScription – CEO**

Thank you.

**Jodi Daniel – ONC – Director Office of Policy & Research**

And just also, the strategy eight does focus on collaborating with federal partners to expand broadband access to support health in healthcare. I just wanted to make sure....

**Paul Egerman – eScription – CEO**

Yes, and thank you for pointing that out, Jodi, because that's actually a very good observation. As you talk about ... future, we start to transmit images with things like MRIs or CAT scan images. Those things take up a huge amount of broadband, and so there will have to be a lot of attention to that issue.

**Operator**

We have another question from Reggie Odem.

**Reginald Odem – RAM NetSoftware, Inc.**

I don't mean to be a pest, but it's Reggie Odem again with RAM NetSoftware. Just in response to the last two callers, there's new technology cloud technology is now being introduced, and it has tremendous potential from both the security standpoint, as well as the bandwidth standpoint. Of course, nothing is 100% safe or reliable. As long as people can brake into banks and do the things that they do, there's potential for any sort of abuse given the best of circumstances.

The other thing is, the caller who preceded the last one raising the issues of the PHR, EHR, the proprietary factors, which make it unable for interoperability. That is a key component of what we are developing, which is an interface, which would allow cross-talk, HL-7, you know, the ability to reach all existing platforms, which of course is critical to any highly functional electronic medical record platform. That's it. Thank you.

**Paul Egerman – eScription – CEO**

That's great, and those are good comments. Yes, the issue of cloud computing, I would personally tend to agree that it has a lot of potential. From the standpoint of the framework document, I think we try not to appear to endorse any specific technologies. But the way you responded also expands the issue that the previous caller raised where he was talking about the reliability of information exchange. At least I

understood that to be the reliability of the network. When you're talking about cloud computing, you're also talking about the reliability of these systems themselves, and that also is a very major issue.

**Reginald Odem – RAM NetSoftware, Inc.**

Absolutely.

**Paul Egerman – eScription – CEO**

But the question becomes, to what extent from a standpoint of strategy and framework should we just allow the private sector to deal with that, or should we be calling that out and addressing it? So far, we don't specifically address that, but if you think we should be doing something different, make sure you tell us.

**Reginald Odem – RAM NetSoftware, Inc.**

Will do. Absolutely. Thank you.

**Suniti Ponkshe - CEO, Ponkshe Consulting Services – Consultant to ONC**

Paul, there was one on the Web that I thought might be useful.

**Paul Egerman – eScription – CEO**

Where is that? I'm sort of little bit lost with all the stuff on the screen.

**Jodi Daniel – ONC – Director Office of Policy & Research**

Sorry. I can read it. It said you mentioned the need to train the vast workforce that'll be necessary to implement this framework. Will it be possible to complete that task before the deadline? I just wanted to highlight that just on Friday we announced some awards for workforce programs totalling \$84 million; \$36 million were going to community college consortium programs, \$10 million for curriculum development, \$32 million for university based programs, and \$6 million for competency examinations. There is a press release on the ONC Web site that identifies the institutions that were granted those awards, so if folks are interested in finding out more about those programs or the awardees, please take a look at the ONC Web site.

**Paul Egerman – eScription – CEO**

I appreciate those comments, Jodi. They way I'd also comment on that is to say we are trying to do throughout the process from the standpoint of the strategic framework is to do things incrementally, and a lot of reasons for the incremental, but one of them is exactly this issue, which is there is a significant workforce training issue. The issues go beyond just training. There are organizational issues. There are lots of challenges in implementing these systems. And so that's the reason why it needs to be done incrementally. Jodi comments are very good also about specific things that ONC are doing that are very helpful. Are there any other comments or questions?

**Operator**

There are none on the line.

**Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO**

Thank you very much, Paul, and thanks to the public for their questions. We'll now move on to privacy and security, and Deven McGraw will lead that discussion.

**Deven McGraw - Center for Democracy & Technology – Director**

Thank you very much, Paul. I'm sure we don't have any questions in this section. I've noticed, actually, I've been reading through the questions online, as ... proceeding, and there were some questions that

came up earlier that if I can, I might try to address in the presentation here. But let's start with the beginning slide, which is the overarching goal. Build public trust and participation in HIT, which of course means health information technology, and electronic health information exchange by incorporating effective privacy and security solutions in every phase of its development, adoption, and use, which we thought was a bit overarching goal, but we'd love comments from the public on this one.

We've identified a number of principles, high-level principles that support this goal, and the first is that privacy and security solutions should be consistent with the nationwide privacy and security framework for electronic exchange of individually identifiable health information. This is a document that was released by the Office of the National Coordinator in December of 2008, and I think a lot of folks are not aware of it because it was released at the end of the year at the very end of an administration, but it is a very good document, and it sets forth a set of high level principles that are based on a number of well understood and frequently used models of fair information practices. And so we've got on this slide the title for each of the principles: individual access, correction, openness and transparency, individual choice, collection use and disclosure limitations, data quality and integrity, safeguards, and accountability.

But I would urge all of you to take a look at the nationwide framework in detail, and in the strategic planning document, there's at least a little bit more explanation beginning on page ten of what's included in these principles. I think it's important to understand these because they really knit together as a kind of comprehensive whole, so that for example there were some questions that came up about what the role of individual choice or consent would be in protecting data. That's a specific question. Of course, the question of choice is one principle, but it's one principle among a number of others that really need to be addressed in order to insure that you've got an effective privacy and security framework of protections that build public trust.

And so I would urge you to take a look at those in a little more detail because I think, again, that that document provides a terrific framework and also a guidepost for thinking about the specific policies and standards and practices that are going to need to be put into place, again, in order to build the public trust, which is essential. It's a really essential building block to making all of this happen.

We have two more principles in the draft framework, as it stands now. The second is that solutions should enhance privacy and security while facilitating the appropriate access, use, and exchange of health information to achieve health outcomes. This is really a recognition that we're not dealing in absolutes here. It's not absolute access to data on one end of the spectrum versus absolute privacy on the other end of the spectrum, but coming up with a set of effective protections that get us really to accomplishing both goals, which is the use of health information in order to improve health and healthcare while also, again, building that public trust that comes through putting into place effective privacy and security solutions.

Then the third principle is that privacy and security solutions should be flexible to adapt to evolving technical capabilities over time, and this is a recognition that we're dealing with a very fluid environment here, which have many benefits, that there are technological innovations being created on a daily basis that can enhance our ability to both have access to information to improve health, but also to protect privacy and security. And the policies that we put into place need to acknowledge the need for this flexibility and, at a minimum, I think, sometimes that means being willing to readdress them periodically to insure that they remain up to date and effective.

We've identified five core objectives to advance both the overarching goal, as well as the principles that we just went through. The first is to develop, promote, and enforce privacy and security laws and appropriate policies for all aspects of HIT and health information exchange. If you peak ahead to look at



the strategies, you'll note that this means both the traditional entities covered under HIPAA, as well as those who are not. Number two, increase understanding, implementation, and enforcement of policies and practices to protect the privacy and security of health information.

I personally think this is quite key because so often there's enormous misunderstanding about what we might already have law to cover and what the law means and what entities need to do to comply with it. Then, of course, on the patient side, it's very important that they understand what their rights are with respect to health data, so there's – I'm personally pleased to see this as an objective.

Number three, review existing privacy and security laws to identify the need for potential modifications and policies to align with emerging HIT and health information exchange capabilities. This, I think, aligns very well with the principle we discussed earlier and a recognition that even though we do have law on the books already in this space, we're dealing with an environment that's already changed significantly and will be changing even more rapidly over the coming years, and we need to acknowledge where those risks are and address them appropriately.

Objective number four is support the availability of accurate electronic health information through safe and reliable health IT, so this is an objective that touches on number of questions that were raised by some of you earlier in the presentation. Number five, increase consumer engagement in health maintenance, healthcare, and accuracy of electronic health information through widespread consumer access.

The next slide just says strategies on it because, of course, the details on the strategies, as they are currently in the framework, are in that longer framework document, and they can be found on pages 11 to 12. I won't go into these in detail because I want to leave as much time as possible for questions because I suspect there will be many in this space. But essentially, one of the early strategies is to assess and implement, as appropriate, federal policies that are related to key privacy and security issues, again, amongst all parties that access or exchange health data for individual or population health.

That includes, for example, implementing the HIPAA modifications that were part of the stimulus legislation commonly known as HITECH. But also deals with protections for entities that are not currently covered by HIPAA, and what are the protections that need to be put in place there? It also involves using the full array of tools that HHS may have in order to implement privacy and security protections. HIPAA modifications is one tool that the Department of Health and Human Services has, but there's also meaningful use criteria, as well as certification criteria that can be used to move privacy and security forward.

Another strategy that I will point out is to implement federal privacy and security policies through guidance and health IT programs, so that includes taking that nationwide framework that we just talked about it, and developing, disseminating, and promoting specific best practices and guidance for how you might comply with that. Again, we've got law already at the federal and at the state level that touches on some of those principles, but we're moving into a new era here, and you could spell that e-r-a or A-R-R-A, where we need to think about what the new risks are and how we can best meet them.

I want to call out two more of the strategies, numbers five and six, promoting an environment of accountability through public education and effective and fair enforcement of legal requirements, which, in my view, what I like a lot about this particular strategy is an understanding that effective enforcement and accountability is both about making sure that people are complying with laws, as well as making sure that stakeholders understand what their legal requirements are and best practices for compliance and what practices they can put in place in their own institutions that can build public trust.

Then the last strategy I'll call out, and then we can move into questions, and again, I urge you all to read all of this because, in the brief amount of time that we had here, I wasn't able to cover all of it. Develop and maintain a national education initiative to increase consumer knowledge about the benefits of health information exchange and to broaden the national dialog on privacy and security issues and enhance public transparency regarding uses of protected health information and individual's rights with regard to protected health information.

Why don't I stop there, and we can go to the question side, and I will let our moderators give the instructions once again, and then I'll go ahead and take an online question. I'll go ahead and take an online question. How to ask a question is, of course, on the slide right now.

EHR adoption is a people issue, not necessarily just technology. It's about change management, behavior modifications, and expectations. People don't want to change their behavior. Eighty percent of the ONC efforts should be on this, and 20% on what ONC has proposed so far.

That's a really excellent question, and I think it gets to the heart of what ONC – in my view, it gets to the heart of what the national coordinator has the tools and resources to be able to control or to manage versus maybe some bigger societal questions about what motivates people to change their behavior that obviously we need to think about in terms of whether any particular strategy that we might employ would actually be effective, but I'm not sure specifically whether ONC would have a tool to address that.

I guess I would say to the questioner, I think we acknowledge where you're coming from. If you want to suggest some strategies that can help influence those pieces of change management and behavior change that you don't think we're reaching through these set of strategies, that in fact ONC actually has the tools to put into place, I think we would welcome hearing those suggestions.

#### **Jodi Daniel – ONC – Director Office of Policy & Research**

This is Jodi Daniel, if I could just jump in on a couple of things on that topic is that when we do have some money devoted to regional extension centers, which is to try to help particularly small providers, primary care providers, to adopt a meaningful use health information technology, and I think a lot of the thinking behind that is that it does require a lot of hands on effort to try to change the way people are doing things, change the workflows, change the way people are thinking about the way they deliver healthcare and the way they capture the information. I think the regional extension centers may be helpful in that regard.

We do also have some other programs in place. We have some evaluation projects we're going to be looking at the adoption and any barriers to adoption, things like that. So there are a couple of activities to deal with this. We do have a large communications contract that we just ... which will also be trying to help communicate some of the benefits of health information technology and some of the things that may sort of start changes people's thinking about the use of health IT and hopefully start moving that thinking from ... standpoint beyond just the incentive dollars that we have.

I think the point is a very good one. I think there are a couple of things that we're working on in that regard. But of course, suggestions on, if there are things that we can be doing within our authority, they are more than welcome.

#### **Deven McGraw - Center for Democracy & Technology – Director**

Latanya, it looks like there's a question on the phone.

#### **Operator**

We have a question from Dan Rode.

**Dan Rode – AHIMA – VP Policy & Government Relations**

Sure. Thank you. This Dan Rode. I'm with AHIMA. Deven, just two comments: one, kind of what we were just talking about, under the objectives number four where it says support availability of accurate electronic health information through safe and reliable health IT. I would suggest you add management that we recognize especially in the area of privacy that this is more than just the technology and that it takes the policies, the procedures, and some of the things Jodi was just talking about to really affect a good privacy activity within any of the entities involved in electronic health information.

Then my second comment relates to education. I think one of the areas that's missing in the strategies is an education aimed at policymakers. I don't want to pick on a particular group, but I will suggest state legislatures and governors. A lot of the laws that our members have to deal with and the balancing act of federal and state laws comes out of legislation at a state level by legislators who do not understand what's going on at this particular time.

While it would be great if we could get there and do that explanation each time a bill is dropped, that's not possible. But we do need some means to educate these policymakers to understand the need for uniformity, to understand the need for consistency and achieve this nationwide plan that's consistent and can be expected by the consumer.

**Deven McGraw - Center for Democracy & Technology – Director**

Dan, those are really good comments. We've been consistently reminded by the folks who are participating in this public meeting that it's so much more about the people issues than it is about the technology, not that there aren't technology challenges that need to be addressed, but I think our your comments were really helpful.

Your question about state law reminded me that there is a strategy that I didn't get to in the explanation that I started this section with, and that is to actively engage states to harmonize privacy laws or exchange policies where it is essential to advancing the national health priority goals. And this, you know, is an issue that we'd like to get some feedback on, as with all of them really in the document. You know, it's a tough one because it implicates a lot of sort of touchy issues about where states have the authority and the desire to do what they think is appropriate for the citizens in their own state. But yet we're trying to create an ability for providers to share data nationwide for treatment and population health purposes. It's an enormous challenge. At a minimum, getting the states more aware of what is going on at the federal level so that we can at least stop the conflicting policies from necessarily being implemented would be helpful. But any specific suggestions that folks have in this regard are also welcome.

**Chris Weaver – Altarum**

Deven, just as a reminder—this is Chris—if folks are on the phone and wish to ask a question, just push star, one to queue up. Thanks, Deven.

**Deven McGraw - Center for Democracy & Technology – Director**

Great. Thank you, Chris. I appreciate it. I'll take another question while we maybe queue up some more folks on the phone. I'll take another question from the Web. Page eight of the framework talks about individual choice. Where is it guaranteed of enforcing patient preferences, it doesn't seem to be addressed by the framework? That's a really good question.

It's actually something that, from a policy and standards standpoint, is actually on the agendas of the health IT policy committee and the standards committee because if there weren't any additional policies on individual choice, we have law that exists today that require providers to get the consent of individual patients in certain circumstances. And so, while I'm not sure that there are ever going to be any guarantees, there certainly is some work to do to, and we haven't talked about this issue specifically, but I think it does fall into the area of implementing policies through both addressing existing policies to make sure that they are up to date with the current technology, and then also making sure that through technology standards, we've got the right criteria in place to make sure that the law can be complied with and enforced.

I don't know if other folks on the phone who are in the workgroup or staff want to add to that. To some degree, I don't know how much this document will drill down into more specific issues like that one that are kind of nested within a broader strategy, but I think that's something we can address when we go through the feedback and think about how to go forward from here.

**Operator**

We have a question from Jim Kretz.

**Jim Kretz – SAMHSA – Project Officer**

This is Jim Kretz with SAMHSA. It appears that the privacy and security keep getting used as one consistent phrase as opposed to be treated separate. Given the last two rounds of public announcements or Web postings regarding authorized disclosures of identifiable patient information, what is being learned from those sort of horrible examples to inform either the framework or the general strategy?

**Deven McGraw - Center for Democracy & Technology – Director**

Good question. There actually is, you know, we've had a breach – there is a strategy, actually, again another one that I didn't highlight, but that you've just given me an opportunity to now, which is to provide more transparency of breach notifications and analyze those breaches in order to identify common issues that ought to inform future privacy and security policies. Even though we talk about those two terms together, I think we at least understand the distinction between the two. Although, with respect to breach, given the breach definition that currently is in effect at the national level, it incorporates both breaches of privacy, as well as security.

But this is where the learning healthcare system discussion at the beginning is applied in the privacy and security context, which is creating some mechanism by which we can learn from what's going on out there with respect to both security and privacy breaches and be able to adjust policies and standards accordingly in order to try to endorse a preventive approach versus a merely reactive one. And the law, the federal breach notification law is actually fairly new, and we're now just really sort of one year into when the legislation was passed. While we certainly have media reports about these particular breach notifications that you mentioned, I think in order for it to really be effective, we would want to have a greater understanding of all of the facts and circumstances that surround them and creating that sort of feedback loop that again can help prevent them in the future.

Are there any other?

**Operator**

Yes, we have another question from Joseph Kahn.

**Joseph Kahn**

This is Joseph Kahn ... healthcare. The December 30<sup>th</sup> or 15<sup>th</sup>, the national privacy and security framework has a definition of privacy in there that calls it an individual's interest in protecting his or her individually identifiable information. Is that what you intend in the framework going forward is to have that, include that definition?

**Deven McGraw - Center for Democracy & Technology – Director**

That's an interesting question because, as you read it, Joe, I don't think it struck me before that it sounds like we're telling individuals to protect their own data, which I think is not what we – maybe a better way to phrase that is an individual's interest in having their data protected versus an individual's interest in individually pursuing data. Is that what you meant?

**Joseph Kahn**

I don't know. I didn't come up with the definition, but it seems to me as if what they're talking about here is the individual has an interest in protecting his own data, and there are other interests out there.

**Don Detmer – American Medical Informatics Assoc. – Pres. & CEO**

Right. This is Don Detmer. Can I make a comment?

**Deven McGraw - Center for Democracy & Technology – Director**

...Don.

**Don Detmer – American Medical Informatics Assoc. – Pres. & CEO**

Yes. I think, the thing is, that could be very interesting. I think we need to get back and discuss it because it could mean that actually I'm interested in sharing my data for research or whatever. It doesn't necessarily mean more exclusion. It's a very good question and a key question.

**Joseph Kahn**

That's the answer.

**Deven McGraw - Center for Democracy & Technology – Director**

Well, you know, this is a question that I think we ought to take back to the workgroup.

**Don Detmer – American Medical Informatics Assoc. – Pres. & CEO**

Absolutely.

**Deven McGraw - Center for Democracy & Technology – Director**

It's not something that I can answer on their behalf because we haven't discussed it, Joe, but it's a good question, and we should.

**Joseph Kahn**

The reason I ask is because, up until this floated around, there really wasn't much of an official definition out of HHS, just what privacy is. The NCVHS, after their hearings in June of, I think it was, 2006, produced a policy statement. They had 26 recommendations in it, and like the second paragraph included a definition of privacy, but that was accepted by the secretary, but I don't know if any of that stuff was adopted. And I don't see that policy statement anywhere referenced in this framework, so do we have a federal definition at this time other than this one of what privacy is?

**Deven McGraw - Center for Democracy & Technology – Director**

This is in a draft document. Yes, I mean, we have that in the nationwide framework, the material from NCVHS. Congress has never officially adopted a definition of privacy. I think we have to talk about the

question that you raised, as well as, again, I would tell you to go to the NCVHS definition and say, they actually defined three terms: privacy, confidentiality, and security. And often the confidentiality piece gets kind of subsumed into the privacy definition, so that's folks think about privacy as both what the individual has the right to control, as well as the obligations on the organizations that hold the data, which is specifically really confidentiality. People tend....

**Joseph Kahn**

The NCVHS said that they define privacy as an individual's right to control their personal information.

**Deven McGraw - Center for Democracy & Technology – Director**

Right, but there's a confidentiality definition that then gets to the issue of what the data holders do with that data once the individual has given it to them. And so, my understanding of it is that it has looked in three different domains what most people crunch into two. And so, therefore, the privacy definition, if it has to cover both domains, I think needs to be thought of in a different way. But now you're getting more of me versus what the workgroup or ONC thinks about this, and so I'm going to stop because this really ought to be an issue that gets taken up more with the workgroup.

**Don Detmer – American Medical Informatics Assoc. – Pres. & CEO**

But I think it's just a terrifically central thing because one of the challenges that policymakers have had for 15 years is that privacy hasn't been kind of nailed down, and it's hard to create good policy if you don't really have a pretty understandable and operational kind of definition for what you're talking about and dealing with. Thank you for the comment.

**Deven McGraw - Center for Democracy & Technology – Director**

Yes, it's a good one, and I'll also say that while that may be the definition of "privacy" that's in the framework, I think you've got to look at all the principles that are in that framework as a whole, of which individual choice is one, but data collection and use limitation, purpose limitation, security safeguards. Again, the concepts of both giving patients some choice, but also what are the obligations of the data holders are expressed throughout the document. Keeping in mind that at least as far as we advisory bodies are concerned, this is just our advice to HHS, which is the ultimate decision maker here, and that's true of NCVHS as well.

Let me see if there's another one online here. All of the strategies are based on compliance, guidance, and best practices related to the security and privacy of the exchange. Where is the strategy and best practice development and testing that patients understand and can identify who providers are that are shown on their records or disclosure reporting.

I thought we did have a strategy about education for consumers, and as far as the identification of providers you were shown on their records or disclosure reporting, again that's a detail that is, on the one hand, about implementing the HIPAA modifications that were included in the HITECH stimulus legislation, which include some improvements—I'm going to call them improvements. People may not agree—to the current HIPAA privacy rule, accounting of disclosure requirement. Similarly, there is, in the certification criteria, interim final rule, an audit trail requirement, so we've got – you know, there are incremental policy decisions that are in support of those bigger strategies that address those points, the patient education point, as well as the issue of patients having greater knowledge of who has received information from their record.

There's another question from online. Is there a strategy in the strategic plan to identify policies, which will require modification or the implementation of new policy? Yes. That is a strategy in the plan. Again, we are, in many respects, fortunate that we're not having to start from scratch in creating privacy and

security protections that will address electronic health data. The HIPAA privacy and security rules apply to paper records, at least the privacy rule does, as well as electronic records. But I think we recognize that we're in a new, we're evolving into more widespread use of electronic health information and health information exchange using potentially through vehicles that didn't exist when the HIPAA privacy rule was initially put into place, and so we do need to assess where the gaps may be and address them through modifications to those rules, and HITECH already requires us to do so in some very specific ways. But the inquiry, according to the strategic framework, is not limited to that. There's an overarching strategy to really take a look at where the laws are today and what modifications will need to be put into place going forward.

Here's another online question: Under HIPAA security entails confidentiality, integrity, and availability, but the privacy and security ... strategies seem to only focus on the confidentiality dimensions. It's a good question. I'm not quite sure how to address it. I will say that part of the focus on the confidentiality aspect of it is because of the tools that ONC has at its disposal, which are a bit more focused on the data holders, which does, might kind of tilt us a little bit more into the aspects that sort of skew more towards confidentiality, as well as through security.

I think, again, we've got a specific strategy in here that involves exploring and promoting existing and emerging technologies to enhance privacy and security, as well as assessing security vulnerabilities and developing initiatives to mitigate them. I guess I would say to the person who asked that question, if you would be more specific about what you think is missing or what you would like for us to consider including, that would be very helpful.

**Jodi Daniel – ONC – Director Office of Policy & Research**

Deven, can I jump in for a second? This is Jodi Daniel.

**Deven McGraw - Center for Democracy & Technology – Director**

Yes.

**Jodi Daniel – ONC – Director Office of Policy & Research**

I think that's actually a very good point, and I think it is addressed in the principles. There is a principle of data quality and integrity, as well as sort of the confidentiality principles. I think that the workgroup at least considered that, although I don't think it's called out specifically, and I do think it is an area that ONC is interested in and needs to focus on. Again, some more concrete suggestions would be helpful, and they might serve as some tactics that ONC might consider within some of these strategies since the strategies are a little bit more high level. So any suggestions if the person who wrote that in wants to add some more or stick it on the blog, that'd be great.

**Deven McGraw - Center for Democracy & Technology – Director**

I think we've gotten through a lot of these. How am I doing on time?

**Jodi Daniel – ONC – Director Office of Policy & Research**

You've got about five minutes.

**Deven McGraw - Center for Democracy & Technology – Director**

Super. We can get some more of these. Yes, I'm trying to go through some of the questions here. Here's a good one that I think we have some answers for, but I don't know that anybody can claim to have the answer. That is, how will consumer confidence be gained with regards to EHRs and HIT?

I think that that might be the \$6 million question or \$60,000 question depending on your TV game show of preference. It's a big one, and that is that we can take a look at, through survey data, what consumers are expressing their interest in when, for example, states are setting up health IT infrastructure and hopefully they have got consumers at the table or consumer organizations that can help provide them with some feedback on how to structure these initiatives so that they deal with and implement effective privacy, confidentiality, and security solutions while also making sure that they're getting the sort of benefits of health IT in terms of individual and population health outcomes that collectively we want to achieve, and that includes the interest of patients and consumers who are very much looking to leverage the benefits of this, as well as being protected.

I don't know that there's one sort of smoking gun solution here. I happen to think that greater transparency of how people's data are used and disclosed and who has access to it is important. I think, if consumers can have a greater understanding of these systems and some means of participating and structuring them, that can go a long way toward building trust. We certainly have seen that in some of the initiatives that the state has stood up to date, as well as with respect to work that's gone on at the VA in structuring their healthcare system. I think there are some lessons learned that I hope we would take into consideration.

I don't think there's a magic bullet here. If folks have some very specific suggestions or think there are some pieces missing in terms of building consumer trust, I think it's going to take a lot of incremental pieces that will need to be put in place in order to make that happen. We would certainly welcome hearing that.

Then I guess we'll take one last question here. How can the framework make certain that privacy and security enforcement efforts are ramped up in a timely way? I think that's a very good question. There is a framework strategy that says that we need to promote an environment of accountability through public education and effective and fair enforcement of legal requirements. Of course, having some tactics that are very specific about what HHS ought to do in order to achieve that particular objective, which then, I think, goes a long way toward building public trust in this.

I think it'd be helpful to hear from you all on that because that is really the next step with respect to making this framework really sort of come alive, for lack of a better way to say it, in terms of implementation. Jodi, I don't know if you had any or if anybody else wanted to add to that.

The enforcement piece of this is quite key from my vantage point, especially when we've got law on the books already that arguably addresses many of the concerns, not all of them, but many of the concerns that people have raised about health IT. We ought to make sure that those laws are effectively enforced in order to give people the reassurance that they're looking for.

I've got a minute by my computer. I'm afraid if I take another question, I'll go over. Unless you all are going to urge me to take another one, I'm going to pause, so we can hear from....

**Patti Brennan – UW-Madison – Moehlman Bascom Professor**

Paul, do you want to take over on the...?

**Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO**

Sure. Let me ask, were there any other workgroup members on the call want to make any comments on any of the feedback we received or any other comments before we close up?

**M**



Just that it's been very helpful. Thanks.

**Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO**

I want to thank the public for dialing in and logging into the Web. This has been very, very helpful, and I think this whole concept of a listening session and dialog is very useful, and we really value your input. We've archived it all. We'll go back as a team with the workgroup to digest it and to see how it can affect this next round of the draft we have for the strategic plan recommendations to ONC. We'll be presenting that at the HIT Policy Committee that meets on April 21<sup>st</sup>. They'll undoubtedly have some additional feedback. We'll be wrapping that into it as well, and producing a final document for their approval in May on our May meeting that would move on to ONC.

ONC then has its process of incorporating, you know, reading and assimilating the recommendations in our recommendations, coming up with their own strategic plan, and going through a clearance process that will ultimately produce the update to the strategic plan, I believe, in October. Is that right, Jodi?

**Jodi Daniel – ONC – Director Office of Policy & Research**

Where things fall.

**Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO**

Where things fall. In the fall....

**Jodi Daniel – ONC – Director Office of Policy & Research**

Exactly.

**Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO**

Yes. But this has been very helpful. As I say, it's been – this is really a momentous time. This past year, everything leading up to the passage of the Health Insurance Reform Bill, the tremendous work that's been going on executing HITECH through ONC and CMS and HHS more broadly, I think, has really done the country a big service. We appreciate everybody's help. We appreciate the help of the workgroup and the staff and officials at ONC.

If there are no other comments, then we'll wrap up this listening session. No further comments? Okay. Well, thank you, everyone, both on the workgroup and ONC and the public.

**Jodi Daniel – ONC – Director Office of Policy & Research**

Thanks, Paul, and thanks, both workgroup members and the public for a robust discussion and for all of your participation. We really appreciate it.

## Public Comment Received During Learning Health System Presentation

1. Language used in the document often suggests that the patient is the passive receiver of information, not the seeker (e.g., the system "will inform and engage patients"). Many patients ARE engaged; often the problem is that the information available is not provided in a form that's understandable by laypersons. It actually hampers individual ability to self-manage their care. Finally, referring to laypersons as patients, also rather undercuts goals like prevention, health, and wellness. Not every layperson looking for information is a patient or looking for information for a patient.
2. I appreciate the recognition of the challenge across the country, i.e. variable resources and capabilities to achieve the desired results. How will the comments from the AHA be taken into account or affect the strategies overall to ensure staging of attainable goals?
3. Edited question: Is there a uniform standard planned for collecting and using 'meaningful' health information?
4. Will EHR Certification be available and affordable to smaller vendors and will the criteria fit with these smaller companies?
5. What you just described is that HIT will become transparent and meaningful use will be practice in matching patient need to consumer action and treatment.
6. Dr. Blumenthal and others at HHS have noted that 'best informing decisions at the point of care' (i.e. CDS) is central to meaningful use and better health care. The framework never explicitly addresses CDS. Can/should the framework address CDS more specifically?
8. How is the committee considering incorporating Patient multimedia into the "Meaningful Use" strategy to address when this media needs to be part of the EMR/EHR and useful when not required? This should address both radiological diagnostic imaging and other specialties such as pathology, dermatology and other disciplines.
10. Will education and knowledge base include information on the impact of belief on health and healing? This is related to culturally tied beliefs and concepts of wellness, illness and healing. Also involved in this discussion would be how to integrate cultural teachings/traditional cultural methods of healing (e.g., sweat lodge, medicine people) in the healing process. Minimally, care should be taken to avoid discounting traditional indigenous methods of healing and effort should be made to have communities have a method to "validate" a healer, i.e., acknowledge as a healer, be known to the community as a healer.
15. Who will take the lead in this transformation? ONC? HHS? Person?
16. I am curious and concerned about the training of future EHR staff. What can you tell us about training program development?

17. Recommend use of the Patient Activation Measure to better tailor the information and intervention to the patient's level of readiness.

18. Are there incentives being created for commercial groups to participate or share industry-gained knowledge with the WG?

19. This is obviously a learning environment for patients. There is some experience such as Kaiser and other releasing Medical Records to a large number of Members/patients. One significant issue has been that provider Information that is shown on the records correctly identifies a provider who has legitimately accessed their records or provided care. However the identification of the provider though great for exchange...confuses the patient/consumer. Experience has shown significant patient/consume confusion and phone calls. Where will the testing environment be for the identification of provider data in a patient/consumer recognizable format? Where will the pilot, test bed of this consumer/patient recognizable identification of the provider information in their records and their disclosure reporting... NOTE this assumes that the proper authorization and security has been achieved for exchange... everything is secure... It is just that the patient needs to have the information necessary to easily identify the

21. How will we eliminate the prepaid discounts in pricing of medical services?

22. I have a question around strategy #5" Incorporate the global health dimension into the interoperability requirements of the learning system infrastructure." How does HIT envision incorporating this as part of the standard?

23. The medical industry will see many new developments in medical devices and their ability to serve as the source of health information directly. How and where will this technology segment be effectively leveraged in this new overall care delivery environment and highlighted as a strategic plan objective?

24. It would be helpful to attach the strategy to an ideal operational picture or set of principles. A description of the components of an ideal healthcare home model and the coordination of medical, dental, behavioral, social services that surround a patient care path.

26. The HITECH initiative represents significant change to both the technical and human systems. The learning system that is being discussed today is a great move toward nurturing an innovative culture that can support meaningful adoption of Health IT. However, will the learning system address change readiness issues early enough to create a virtuous cycle within which adoption can thrive a vigorous way?

27. What types of metrics have you considered from the patient side? What is "criteria for success"? How do we know we are doing well or need to improve?

28. Regarding Slide 6, I am concerned that the Adoption of EHR relationship to Exchange of health information is not correlated, and each is simultaneous, rather than linear. Wouldn't a framework of Standards and Certifications need to proceed, and feed into Adoption of EHRs?

29. It is encouraging to see that a distinction is being made between public and population health. The latter, however, is usually defined to include the social determinants of health. It would be good to see consideration of how HIT can address this aspect, and specifically, it would be beneficial to include mention of the social determinants of health in strategy number 6.

30. e.g., the Learning Community should seek to learn about patient safety opportunities/needs, which will reduce injuries and deaths as well as improve efficiencies and costs. As a clarification, I am posing the question about general patient safety improvements beyond the scope solely of medical errors.

33. Critical to any successful EHR implementation is a comprehensive communication and engagement strategy with all stakeholders including patients - How are you working to ensure that the tools we develop are based on consumer centered design principals versus simply viewing them as recipients of data? IE why not require that patients get access at the same time as providers do to their EHR?

34. How does the strategic framework work with so-called "system redesign"? it seems as if HIT is considered a deus ex machina to improve care, but as we've seen the policy and culture have limited the potential of health IT to lead to improvements.

36. How will the benefits of a learning health system be realized?

39. As related to Objective 3- Are there any national initiatives to educate patients/consumers regarding privacy protections in the event there are fears of being forthright about health matters because of the thought that the information will be accessible by unauthorized individuals/companies?

40. Will the HIT system allow for an individual acquire a history of their health records? My concern if I am see a number of doctors how I can provide them a history of my medical conditions and treatments.

41. Who will take the lead in this delivery of the healthcare delivery system?

42. Patient awareness of barriers and opportunities of HIT is currently very low. There is a vital need to reach out to general public. Is there anything being done?

43. On Slide 8 - Principles: it seems that health information is primarily defined as general health information in this and not personal health information. However, HIT generally is used as much or more for personal health information. Should you consider both types of health information?

44. It appears to me that the strategy depends heavily on clearly defined performance measures which will need a certification authority and process to ensure that the measures that are being properly made. What is the current thinking about how to accomplish this?

46. I understand and support the framework for establishing the goals, principles, etc. Is the team going to set any metrics or measures to measure if the Learning Health System framework is successful?

48. Could you please define the "global health dimension" (Theme 4: Learning Health System, strategies, #9)?

49. I would suggest that this framework include critically evaluating implementation strategies and making recommendations to those organizations looking to embrace HIT, helping to ensure its effective adoption.

50. Does "engage consumers" include guaranteeing a patient choice not to participate i.e. not to permit identifiable health data to be used/shared?

51. Do you plan to require that the patient give permission to share anonymous clinical information?

53. Do you support opt-in or opt-out for individual data collection?

54. Have you made any specific arrangements with the European Union?

56. Would you advise HIM professionals to get certified as CPEHR & CPHIT professionals?

57. How will we know when we've achieved these objectives?

## **Public Comment Received During Meaningful Use of Health IT Presentation**

58. How will you encourage those who do not want to participate, both on the public and private levels?

60. I would add the word "collaboration" to the first principle; i.e. ". . . facilitate learning, collaboration and innovation . . ." Do you agree?

61. On slide 5, "informed" patients were listed under the results section. Why not "activated" or "engaged" patients, especially given Patti Brennan's description of the learning principles on slide 8? Being an informed patient is not enough.

62. Learning Health System Obj 4: Should also include use of data for public/population health purposes, right?

63. Could/should the Learning Health Systems please include a Patient Safety objective?

64. Learning Health System Obj 1: should include HIT Architecture in addition to HIT methodologies, standards and policies.

66. I would like to encourage the integration of stages of change - educating consumers, educating medical personnel, educating policy makers - it is critical to healthcare change, organization change, and more. Thank you for an informative experience.

68. I would suggest that the document be reviewed, overall, for how patient-centered the proposed plan REALLY is. And should it really be PATIENT-centered anyway, or USER-centered, with patients just one of many user groups whose needs are relevant. There is not a sense, in the document, of what consumer needs/goals are, relative to the goals of other stakeholders. Although this plan at least includes consumers/patients/laypersons, whereas the 2008-2012 plan really did not to any extent at all, it really needs to go much farther, and it needs to consider laypersons as proactive information seekers with respect to their health. After all....it is no small thing that health information is goal of a huge percentage of the information seeking on the internet. This should tell us something. They need to be able to understand EHR information.

69. It is apparent that you all have taken a very thorough and thoughtful approach. Thank you

70. Could the privacy workgroup please consider the following case when considering limiting the scope of individual choice to only individually identifiable data?

<http://www.texascivilrightsproject.org/?p=1096> It just reinforces the need for transparency.

\* (Private response removed from transcript)

71. Do you understand HIPAA's exceptions for treatment, payment, and healthcare data exchange preempts state patient-physician privilege statutes?

72. Elliot B. Sloane, PhD/Drexel Univ: The Integrity and Availability of data and systems can cause serious patient safety risks. A single lost/delayed pathology or drug interaction report/warning could cause a mistake that might not be discovered until it is too late. i.e., if a drug allergy alert does not get to the physician or pharmacist before the drug is dispensed, the patient can be harmed. There are no metrics presently for "how current" an EHR system should be, nor is there any significant attention given to validating that two or more interoperable systems can and do transfer critical information completely, accurately, and in a time-specific fashion.

74. If everything is Legal, secure and private within the exchange process ... what is the information necessary not to assure providers and payers are satisfied... what information is necessary for the PATIENT to believe that has been achieved. What information is necessary on the audit reporting to make sure the Patient can understand the audit reporting... as a Patient a name and say NPI is not satisfactory... as a provider that might be fine

75. How will consumer confidence be gained with regards to EHRs and HIT?

77. On what basis could privacy be understood as something other than Roe v Wade or NCVHS' notion of patient control?

78. On privacy, patient consent seems meaningless in an environment where standard consent forms give full, unlimited power to the provider to disclose all data to any party without time limit. How can a consumer protect data once it has been released to the health information world? Can a consumer restrict information that has been released in confidence to a given provider? Can a consumer prevent information being released by a child or other family member who is not authorized by the consumer? (For example, as part of a medical history taken from a young adult who reveals sensitive information about the parent when the parent is not willing to release it?)

79. For a definition of "privacy" one might look to the Supreme Court's Roe V Wade decision and opinions.

80. The statement of desired harmonization could be cautiously worded to "encourage open and effective dialog" between the state and federal regulators to begin harmonization where/as justified by the benefits to patients, providers, payers, and all other stakeholders.

81. I would strongly recommend that an overarching Policy and Infrastructure Strategy should be encouraging national/state harmonization of HIT regulations, including, for example, ePrescribing, ePHI privacy/confidentiality terminology and regulations, etc.

82. Is there a strategy in the strategic plan to identify policies which would require modification or the implementation of new policy?

83. How can the framework make certain that privacy/security enforcement efforts are ramped up in a timely way?

84. Will patient records be handled by a system within the United States, or will outsourcing be incorporated as well?

85. Health-related occupational professional boards should be required to review regulations to ensure regs do not conflict with national policies and goals with respect to accessing/sharing health information.

## **Public Comment Received During Policy & Technology Infrastructure Presentation**

86. I would like to suggest that objective #3 for Priv. & Sec. address harmonization of state Identity Theft Laws as well.

87. I would like to suggest that the Privacy and Security Theme include the wording to express commitment/concern about the above two topics before it is released.

88. Under HIPAA, Security entails Confidentiality, Integrity, and Availability, but the Privacy and Security Theme Strategies seem to only focus on the confidentiality dimensions.

89. National Governors Ass., AHIMA's SLHIE, are 2 of the groups that might be used to coordinate education of state legislators with ONC's strategic planning and goals.

90. The HIPAA rules put the onus of securing data on the provider. Shouldn't regulations penalize any individual/organization that steals/tamper/steals with ePHI? Laws lag technology, but there ARE existing laws preventing tampering with mail and tapping phone lines, but the main focus of punishment for privacy/security violation in our field remains on the provider/owner of the EHRs.

91. In response to the 1st Q, I would suggest that while security of patient-level information is paramount, patients are often not the best qualified to make decisions regarding the use of their health information, & perhaps we need to consider use of "shock" information to help incent patients to become better consumers...nothing really risky, there's lots of areas in diet & exercise, diabetes & HTN, that the majority of patients should be embarrassed about, if you were to show them where they compared to national averages, for instance.

92. Objectives are great. However all of the strategies are based on compliance/guidance and best practices related to security and privacy of the exchange. There is also education for patients etc about benefits of Health IT etc. Even if all the requirements are met and are done legally for exchange, where is the strategy and best practice development and testing that patients understand and can identify who providers are that are shown on their records or disclosure reporting?

93. How do you propose managing people who opt in or opt out of allowing the collection and storage of their health information?

94. ONC is a federal lab to inspire learning locally no matter the size of center. ONC can help by capturing the stories and reporting on change for meaningful use which I am trying to do without funding. My proposal to AU accomplishes that and is a source of support to regional centers.

95. Still intend to "explore and promote, where appropriate, existing and emerging technologies to enhance privacy and security? If so, how so?

97. Since only one third of the American population has a computer in their home, how will the public at large gain access to health information and/or their health care records?

98. What specific efforts are being made to ensure privacy around HIV and alcohol/drug addiction information? There are laws (federal and state) on the books and go beyond HIPPA and have very specific release of information and re-release of information protocols/protections.

99. The charter of ONC is not to change people. The strategy of ONC is to facilitate systemic change. The tools have to be person to person, region to region.

100. Is there a map or guide in describing how HIPAA is integrated into HITECH?

101. Regarding policy and technology infrastructure, I'd suggest that you ask IT vendors to recommend appropriate service level agreement specifications addressing reliability, redundancy and security for network and data repository infrastructure.

103. Page eight of the framework talks about individual choice. Where is a guarantee of enforcing patient preferences? It does not seem addressed by the framework. Recently proposed changes to HIPAA Privacy Rule did not address this kind of protection.

104. In working with data privacy in other fields, we've found the method of individual choice re: data sharing can vary widely state to state. For health records is an individual "opted in" to data sharing by default until they make an election, or are they "opted out"? Should the privacy theme express a principle on disposition of data sharing prior to an individual making an election? The individual choice section on the nationwide framework is somewhat vague on this point.

105. The cybercrime issue isn't just with PHI on consumer's PC's where anti-virus software offers little or no protection, it is with 70% to 75% of the physicians who practice in solo or small practices without IT expertise or security officers. What is the plan to secure these physician's PC's and EMR information over the Internet? New Malware requires new security solutions. How do you keep ahead of Medical ID fraud from all over the world?

106. One key concern for women's health is the disclosure of women's health procedures to other providers or care givers who might not support that choice. For example does your eye doctor really need to know a patient has had an abortion? There are over 1 million abortions a year and privacy and trust is paramount around this very hot button issue.

109. YES, most definitely. You need to set up a training Lab. I worked as a volunteer on something similar in Silicon Valley that created a networked education process. We got derailed because someone took our funding from us at a community college to pay full time staff. Would



you like to give me your email address and I can share with you the Australia state proposal I created for the Association of health Service Executives, which is now being reviewed by leaders in Melbourne, Adelaide and informally in Sydney? BTW I have a simple document I did 3 pages for Veterans Health that has been seen by retired military in Colin Powell's network and they could not fund.

110. Privacy and Security-Accountability- Who, and how will they, monitor implementation and adherence to the principles enumerated? I assume certification will require a minimum level of security, but will there be identified levels of security and security ratings/scores for security systems?

113. Following questions were regarding Objective 1 from Policy and Technology Infrastructure session. In addition to interoperability, functionality, utility, and security of HIT, should standard also require the infrastructure to be reliable, meaning will the infrastructure have enough bandwidth to prevent bottleneck and errors to enable databases to be communicated with each other seamlessly? In addition, will the infrastructure be survivable in a catastrophic event?

114. This (EHR adoption) is a people issue not necessarily just technology, etc. that I have seen so far in what I have read in the framework. It is about change management, behavior modification, expectations. People don't want to change their behavior. 80% of the ONC effort should be on this and 20% on everything else ONC has proposed so far.

115. Could stage of change questions be integrated that could, depending on the answer, provide information framed in a manner that responds to the stage that person is in? (Example: a person reports drinking 5 alcoholic beverages a day, feedback could note the % of people who report drinking on that level). For that matter, can the entire experience of the interaction a patient might have with their EHR/PHR respond to their cultural status, e.g., have them choose background images, colors, even cultural symbols?

## **Public Comment Received During Privacy & Security**

116. It is great progress to have the right policies, standards and vocabularies are important but not sufficient for achieving interoperability of HIT systems. As a Health Enterprise Architect, I am a firm proponent of standards, policies and methodologies. It seems to me that lot more will be required. Will continue to evolve this thinking forward...

117. The broadband initiative and FCC's RHCP Program is working to that end: i.e., bandwidth, reliability.

118. Following up on the question about how to combine data from multiple EHR's into 1 consolidated record, is this workgroup willing to advocate a position with regard to a national healthcare id?

119. Since you are trying to create standards, are you interacting with the World Wide Consortium, which will hopefully provide you with tools?

120. You mentioned the need to train the vast workforce that will be necessary to implement this framework, but will it be possible to complete that task before the deadlines?

121. Will you consider a specific mechanism to monitor specific patient safety concerns or incidents?

122. With all due respect, the Policy and Technology Infrastructure Theme truly needs a Strategy that commemorates a commitment to consistency, backwards compatibility, stability, etc. There have been three Senior ONC leaders, and three substantially different sets of Policy and Technology Infrastructure Themes. HUGE technical resources have been devoted to fulfill each of the first two Themes, and both vendors and providers repeatedly invested heavily to learn and accommodate those priorities. That prior work should not be abandoned and/or denigrated completely, nor should future ONC leadership simply abandon this current generation of goals, techniques, priorities, and technologies. Reusability of prior intellectual and technical capital should be considered and retained. Hospitals, physicians, and patients can no more afford to throw out last year's systems than automobile, aircraft, or general computer users could afford such a strategy in their respective industries.

123. How/who will we ensure multiple EHRs, PHRs that contain my health records will be integrated into a integrated HIE, EHRs, PHRs? right now every provider and clinical system is different and most patient's medical records will reside across in multiple medical systems.

124. The comment on patient safety refers to those that arise from HIT. Perhaps we also need reference to a "culture of safety" and "continuous improvement" on existing patient safety issues. In order to optimally "engage" consumers/patients, it would be helpful for them to realize that health care "safety" (not just HIT safety) is a shared continuous responsibility. Thank you for the opportunity to comment.

125. Since patients are to be involved in the process of hit, does that mean that meaningful use will be dependent on patient satisfaction?

126. Has the framework addressed minors' access to their EHR?

127. Will the HIT infrastructure allow entities to leverage current investments and technologies that are proven and currently providing value.

128. What will be done to protect access to patient records and how will anybody know who accessed the records?

129. Will the Framework clearly identify "public" vs. "private" components of the overall health system? In this sense "public" is used in the sense of a "commons" which would include those elements such as empirical research results and knowledge bases that are best served through cooperative processes. "Private" components might include devices or scarce resources that are best served through competitive processes? Right now there's a great deal of uncertainty in the marketplace regarding the basis for competition or cooperation, where cooperation might best take place, and who benefits from cooperation whether in the care of an individual patient or a public health issue. For example, what aspect of meaningful use feed into "Public" elements of the Learning Health System? By clearly defining the "Public" elements and establish a basis for cooperation the Framework could help guide both public and private actors. The EHR certification guidelines do try to provide something of a basis for competition in EHR's b.

130. Regarding Personal Health Records, is there an acceptable model, or technical specification, for PHR content, such as the AHIMA PHR forms?

131. It seems that important parts of adapting HIT across the nation are standard formats for that information. While images are critical diagnostic information, text and data formats are much more efficient for sharing information among providers. The cost of transferring and storing diagnostic imaging is prohibitive. What is being done to standardize formats and health information exchanges?

132. Policy & Tech Infrastructure Principles: Consistent, integrated HIT architecture, standards should be used at Federal, States, Regional, Health exchange and Clinical levels! (Please consider extending or adding this critical principle)

133. I was a big critic of all of this. Until yesterday when Blumenthal and Brailer talked to each other. I have been an advocate of NHIN since Booz Allen Hamilton did the HHS report on NHIN for Leavitt and Brailer. I can talk about all of this in a patient centric way with real practical understanding to build trust. If I could have my dream job in this phase of my life I would be a trust builder to inspiring a NHIN into practice. I have two states in Australia looking at funding a proposal to coach health service leaders on how to lead this change in AU. I continue to do what I can to take my passion and competence into the community of practice that is not IT norm and is practice and patient centric valuable. Some days I feel the wall in front of me is too high to climb to be heard, Yet I have a practical vision and knowledge both as a leader in my former early stage career in Harvard Community Health Plan and my 20 years of intelligent family care giving and learning what 1 out of every 2 Americans face.

134. Will an infrastructure be built specifically for patient health records (i.e. a PHR standardization that allows patients to gain access to their health records across the healthcare spectrum and across the different EHR tools that will be used).

135. As a means for providing patient safety, will hazard analyses be a required part of the software development process?

140. Are the principles, objectives and strategies of the Privacy and Security theme (Theme 3) sufficient to cover the possible exchange of health information internationally as implied by strategies 3 & 5 under the Learning Health System (theme 4)? My reading seems to indicate the principles, and therefore the follow on objectives and strategies, in Theme 3 should be enhanced to indicate the heightened data security requirements needed to enable safe exchange of information internationally even though the data is not individually identifiable. The data and privacy security requirements for this type of data exchange will likely extend beyond the "Nationwide Privacy and Security Framework for Electronic Exchange of Individually Identifiable Health Information" that appears to be the driving factor behind Theme 3. I feel this is an important point to explicitly address at the strategic level given the national security concerns that can arise from the accidental or malicious release of this type of data which can be used by adverse parties to design and develop advanced/targeted biological weapons.

141. Pharmacists are required as a result of Medicare Part D to provide medication therapy management for Medicare Part D. These professional services, which are reimbursed by Part D plans are hampered by the lack of patient information. Please consider including pharmacists as providers of care that must be included in the continuum of care for their medication therapy management role and not only for Medicare.

144. Shouldn't PHRs used by patients (supplied by their health plans, employers or public PHR vendors) and medical devices with stored data used by patients (examples: insulin pump;

glucose meter) have more prominence in the adoption and meaningful use of health information technology?

145. Objective 5 talks about reducing disparities. Simply providing access to the right information at the right time will not achieve this. I recommend separating out reducing disparities into a separate objective and additional thought be given to how HIT can positively impact inequities (which itself is a better term than disparities).

146. Since only one third of the American population has a computer in their home, how will the public at large gain access to health information and/or their health care records?

147. What is the mechanism for documenting race/ethnicity? i.e., how do you document a 'black Hispanic'?

149. How is EHR usability going to be measured so that it can be improved?

150. Are you considering any consumer incentives, perhaps from the insurers, for consumers to learn and effectively use health information to promote self-management, etc.?

151. I would like to suggest that the committee consider a broader context for the many Patient Safety can and should be included in all four Strategy Components. The strategic framework Themes seem to compartmentalize incomplete patient safety issues. e.g., the HIT system can create Patient Safety risks; the learning community can fail to perceive and address patient safety risks, including those arising from patient confusion/misinformation; Private and Secure systems could block access to critical patient-related information, and/or loss/damage/delay/tampering of data could introduce patient safety risks; the Policy and Technical Infrastructure Theme should address systemic failure, fraud, and even basic human-technology issues like user interfaces, font sizes, colors, and alarm/alert integration/conflict, not to mention the risks/problems of rapid system updates/changes leading to patient/human overload and mistakes. All of this is to suggest/recommend that the committee spend time before the final framework is released to revisit the broad area of Patient Safety one final time. Thank you.

152. How do we "encourage health care professionals not eligible for meaningful use incentives to achieve meaningful use and improve health outcomes"?

153. One in four providers will be using the same EHR vendor in the US after they finish current roll-outs and it has a robust patient portal - why not open it up? Group Health gave their patient members access even before the providers and now has the highest adoption rates by consumers (over 50% of 580,000) in the US. (Their CEO Judy Faulkner sits on the Policy committee.)

154. Has anyone demonstrated empirically that the quality measures included in the definition of "meaningful use" can actually be met? A 2008 Rand study suggests not. Partners Health in Boston, using CCHIT certified software believes they cannot meet those requirements.

155. How do you expect to get all doctors and facilities on board with the EMR, when there are so many small offices that cannot afford to implement an EMR and are not able to chase in on the stimulus bill?

156. What is the ONC doing to promote data standards harmonization to promote effective interoperability between systems for health information exchange.

157. Will workforce development efforts include training for older practitioners and staff members who may be less comfortable with information technology?

158. In regards to point #4, health care professionals need to be included to improve health and health care. However, ONC continues to make recommendations without practicing physician input, especially specialty physicians. How can the strategic plan be successful when the people who are essential to making the program successful, physicians, are excluded from the committees and are not included in the preliminary discussions? Often recommendations are not realistic in all practice settings for various reasons.